ALAGAPPA UNIVERSITY

KARAIKUDI - 630 003, TAMILNADU

DIRECTORATE OF DISTANCE EDUCATION

M.B.A. (Hospital Management)



Paper 4.1

HOSPITAL RECORDS MANAGEMENT

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AU / DDE / D5 / Printing / 10 / 2016 date: 12-08-2016 ; Copies - 1000
Printed at Powerfull Printers Pvt. Ltd., Chennai - 29. Ph: 23743502

Books for Reference:

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2. Principles of Hospital Administration and Planning, BM Sakharkar, Jaypee Brothers, I Ed
3. Hospital and Health Service Administration, Syed Amin Tabish, Oxford University Press, I Ed.
4. Medical Records Organisation & Management, G. D. Mogli, Jaypee Brothers.

Course Material Prepared by:

Mrs. S. Mahalakshmi, MA, M. Phil, PGHHM, PGD PM&IR

Principal, Apollo Institute of Hospital Management

& Allied Sciences, Chennai

UNIT I

HISTORY & SIGNIFICANCE OF MEDICAL RECORDS

HISTORY OF MEDICAL RECORDS

The history of the medical records parallels the history of medicines. Permittivity medical records carved in wood and chipped in stones date back to approximately to 2500 B.C. In subsequent centuries, hieroglyphics found on parchments recorded scientific progress. Although very different from modern medical records, these chronicles preserved medical achievements of those eras for latter generation. Throughout the millennia, **medical records** have evolved in conjunctions with the advances in the art and science of medicines.

Ample evidence exists to substantiate the flourishing of medical practice in India many centuries before the birth of Christ. Art forms such as the icons, friezes, and frescoes in the caves and temples of Ajanta and Ellora and on the Buddhists stupas of Amaravathi and Nagarjuna Konda portray medical concepts. There are in numerable reference to the science of medicine and surgery in Indian epics like Mahabharata and Ramayana. The earliest documentation of medical practice in India is found in Athervaveda. The first Indian Text book of medicine Athreya Samhita was written by the sage Athreya during the sutra period following the. Vedic ages; this book united previously scattered medical care details into a comprehensive compendium. Agnivesa Samhita also documents that art of healing in a text book containing about twelve thousand verses.

Charaka Samhita represents the view point of numerous scholars through many centuries, beginning with practice during the period of Agnivesa and ending with those propounded by dridhavala, fifteen centuries latter. This Samhita excellently records a glorious period of creative Indian medicine. Susruta Samhita became the first Indian Text book of surgery describing twenty sharp and one hundred and one blunt surgical instruments, methods of preparation for major surgery, and native methods for anesthesia administration. Ashtanga Hirdaya by Vegabhatta described surgical procedures and discussed innovative drugs for medical care. The translation of this work from Sanskrit to

Persian by Ali Mohammed Ben Ali Ismail Asavali Asseli as Tibb Shifa Mohammed Sahi is considered an outstanding master piece.

Among the earliest existing medical document is a papyrus presenting forty-eight cases attributed to the Egyptian physician imhotep (circa 2500BC). A thirteen -inch wide replica of this original document generated about 1600 BC is in the possession of the New York academy of medicine. Another prized medical record of this period is the Ebers papyrus which antedates the exodus of the Israelites from Egypt.

Ancient Greek medicine was influenced by contribution from Egypt, Babylon, and Assyria. Greek medicine inaugurated a scientific approach into the art of healing. Health care records, including the names of patients coinciding with their medical histories and treatment results were found on the columns in the ruins of the temples at Epidaurus, a seaport west of Athens, across the gulf of Aegina. Hippocrates, the father of medicine (around 460 BC), authored the oath bearing his name, still sworn by physicians today. Hippocrates maintained detailed case reports of his patients in ancients Greece.

Saint Bartholomew's hospital in London, England is the only hospital still in existence where records and manuscripts have been preserved since its inception in 1137 AD this hospital is credited with the first medical record department. An authentic manuscript edited by Sir Norman Moore contains twenty-eight original case histories. During the reign of King Henry VII (1509-1547 AD) regulations were promulgated for the management of Saint Bartholomew's, and the confidentiality of medical records was one of the provisions.

Andrew Vesalius (1501-1564), a Belgian acclaimed for his contribution to anatomy diligently recorded his medical findings. The significance of medical documentation gradually increased throughout the ages.

The first incorporated hospital in the United States, the Pennsylvania hospital, was established by Benjamin Franklin in 1752. This institution preserved continuous, detailed medical records from that time. New York hospital in New York City and Massachusetts general hospital in Boston, Massachusetts, are institution that has preserved medical records since the early nineteenth century. The latter hospital

appointed Mrs. Grace whiting Myers (1859-1957) as its initial medical record librarian. She later became the first president of the association of medical record librarians of North America (now knows as the "American health information management association").

The American hospital association discussed the subject of medical records at the convention held in 1902. The problem of lack of uniformity in medical reports, the lack of centralized medical record services in health care institution, and the often indifferent attitudes of physicians towards the documentation of patient care, were highlighted at this meeting.

Medical Records in Western Countries

Changing circumstances are responsible for stimulating the evolution of improved methods. The greatest improvement in medical record services derived from the hospital standardization movement in 1918, and ultimately led to improved organization of medical record services and medical record staff.

The hospital standardization movement set forth minimum requirements for facilities including one which stated "that accurate and complete case records be written for all patients and filed in an accessible manner in the hospital". Surveys of hospitals in 1918 revealed that only 89 of the 5323 hospitals in the United States conformed to these minimum requirements for medical records. However, progress in standardization and accreditation was rapid. By 1963, more than seventy percent of eligible American hospitals complied with the standards of the joint commission on accreditation of hospitals (now known as the joint commission on accreditation of health care organization).

The medical record department became an indispensable service in every hospital with the adherence to minimum standards for the content of each patient's health record including : identification data; chief complaint; personal medical history; family medical history; history of present illness; physical examination report; physicians' orders; clinical laboratory report; radiological and other diagnostic imaging reports; provisional diagnoses; operative and procedural reports; gross and microscopic pathological reports; progress notes; final

diagnoses; statement of condition on discharge; follow-up recommendations; and in cases of death; autopsy reports.

By the onset of the twentieth century, a more vigorous and wider acceptance of the utility and function of accurate and complete patient case records became apparent in the United Kingdom. After World War I, physicians used case records to study the outcome of new techniques in medicine and surgery. During World War II, standardized documentation maintained through the air raid casualty and service records as part of the emergency medical service was introduced in the United Kingdom. In the post-war era, the medical profession increasingly realized the potential of accurate and complete patient care records for studying the result of the health care rendered.

The National Health Service was established in 1948 with a consequent demand for health information from clinical records. Statistical analysis and assessment based on medical records enabled review and planning of health care services as well as health care financial management. Standardization of patient care records also progressed in Britain. In 1961, the central health service created a subcommittee for standardization of hospital medical records.

The evolutionary changes in health care in western countries greatly contributed to the scientific formulation and development of accurate and complete medical records. No acute care hospital exists without a medical record department and its services. The advent and widespread use of computer technology has revolutionized the entire process of documentation storage and retrieval. Medical record administration has become health information management.

The medical record is essentially a document which supplies:

- A basis for continuity of patient care.
- A fundamental means of communication among health care personnel.
- A source for comparative studies and research.
- A medium of education for medical and paramedical personnel , and
- Legal protection for institutions, practitioners, and patients.

Among the most significant milestones and landmark in the recent history of medical record science are:

- American and British endeavours to standardize medical records through formal accreditation processes.
- Organization of National Medical Record associations the USA (1928), Canada (1942), Great Britain (1948), Australia (1952), India (1972), and so forth.
- Founding of the international federation of medical records in Stockholm, Sweden in1968. Current member countries of this organization are: Australia, Canada, France, Germany, Great Britain, Israel, Jamaica, Japan, Kenya, Netherlands, New Zealand, Nigeria, Philippines, South Korea, USA, and Venezuela.

Worldwide associations of medical record personnel foster the development of international standards and facilitate uniform statistical comparisons of health data and disease classification systems. The international federation of health record organization was initially recognized by the world health organizations in 1968 when the federation was invited to participate in the first world study group on hospital records in Geneva , Switzerland in November 1969 .

For over twenty years , the world health organization has sponsored workshops and conducted sundry educational programs in various health information Personnel. since January 1979 , the relationship between the world health organization and the international federation of health record organization has been on formal basis. The first international congress on medical records was held in London, England in 1952; the twelfth international congress on health records was held at Munich, Germany in April 1996. The thirteenth international congress on health records is proposed to be held in Australia in October 2000.

Patient records are believed to have been kept in ancient India by physicians in emperor Ashoka's time (200 BC). In seventeenth century, St. Bartholomew's hospitals in London first started to keep written records, which were later followed by some hospitals in USA. However,

the impetus to the idea of proper written records came in USA from the American College of Surgeons and American College of Physicians in the beginning of this century. In 1928, the Association of Medical record Librarians was formed in USA. In India the Mudaliar Committee (1963) first stressed its importunate and the subsequent review committee for health and hospitals (Jain committee, 1968) lamented the poor state of medical records and strongly recommended establishment of proper medical record sections in every hospital. However, the progress in this matter has not been very satisfactory, with only lip service being paid to this aspect by most of the hospitals. Only some government hospitals have properly organised medical records department besides some voluntary hospitals.

Medical authorities in India have been slow to realise the potential of good medial records in hospital in improving patient care or of the seriousness of problems that poor medical records create. One of the most important reasons why enough emphasis has not been placed in the past in development of good medical records systems is that there is no regulatory control on quality of care (Medical Audit) either by the central or by state medical authorities, nether care there any accreditation requirements from any of the professional associations in the field like Indian Medical Association, Indian Hospital Association, Indian Society of Health Administrators to mention only a few out of many such organisations. Medical insurance that requires maintenance of good medical records has had been almost nonexistent till recently and there have been very few malpractice suits against hospitals in India, thus, pushing the requirement of good medical records to the background. However things have gradually changed over the past some decades wherein the importance of good medical records system in hospitals are being increasingly realised.

MEDICAL RECORD

Medical record can be defined as an orderly written document encompassing the patient's identification data, health history, physical examination findings, laboratory report, diagnosis, treatment and surgical procedures and hospital course. When complete, the record

should contain sufficient data to justify the investigations, diagnosis, treatment, length of hotel stay, results of care, and future courses of action.

Purpose of Medical Record

- The primary purpose of the medical record is to accurately and sufficiently document the health history of a patient, including past and present illness or illnesses and treatments prescribed with special attention on the events affecting the patient during the current episode of care.
- To provide a means of communication among physicians, nurses and other allied health care professionals
- To serve as an easy reference for providing continuity in patient care
- To furnish documentary evidence of care provided in the health care facility
- To serve as an informational document to assist in the quality review of patient care
- To protect the patient, physician as well as the health care institution and its employees in the event of litigation
- To render clinical an administrative data required for budgeting, management, service development, planning , review, medical education, and medical research
- To supply pertinent patient care information to authorised originations and third party payers

Medical records are important "People forget and records remember". The record is valuable to many individuals and groups: patients, physicians, health care institutions, research teams, teachers, students, national health agencies and international health organisations.

A medical record is defined as clinical, scientific, administrative and legal document relating to patient care in which sufficient data is written in the sequence of events to justify the diagnosis, treatment and the end results.

The medical record today is a compilation of the pertinent facts relating to patient's health history, including past and present illness or illness and treatment prescribed by health professionals contributing to the patient's care. The medical record should be complied chronologically and should contain sufficient data to identify the patient, support the diagnosis or the reason for the treatment, justify the treatment and accurately document the result.

The medical record professional must ensure that it contains all the relevant facts needed for patient care and other uses. The process of ensuring that the medical record is adequate, compete and useful, requires a though knowledge not only of the content, but also about information regarding the purpose, ownership, value, uses of and responsibility for the medical record.

The medical record is assembled after the discharge of the patient, so as to facilitate the logical flow of information regarding the patient's past and present illness, diagnosis, treatment and the outcome. The information must be available readily as and when required for several purposes, for example patient care, legal affairs, research, education, quality review, correspondence and so on.

Ownership

The medical record developed in the hospital or its branches is considered to be the physical property of the hospital. However, the data contained in it is the property of the patient and thus, must be available to the patient and to the patient's legally designated access to the medical record vary according to the law of the country or state. However, it does not prevent other from submitting legitimate claims to see and copy the information therein.

DEVELOPMENT AND CONTENT OF THE HOSPITAL MEDICAL RECORD

The medical record establishes facts regarding what a hospital is accomplishing. The wealth of data available in the medical record enables the management to make important decisions and review the quality of care given to the patient, thus it is imperative to maintain an

accurate and well documented medical record for each patient for every episode of care.

The medical record is compiled of data documented by different entitles in the hospital. The data is broadly classified into two groups.

- Administrative data
- Clinical data

Administrative Data

It comprises the following records or forms

Face Sheet or Registration Record

This form contains the socio demographic data of the patient, which is part of the basic identification data of the patient. This record also has specific clinical data such as details of allergies, if any, the final diagnosis and procedures, if any and the ICD codes for them.

Authorisation Form

The back of the registration record is often used for the authorisation form which has the following statements.

- That the patient agrees to receive basic and standard procedures for treatment
- That the hospital does not guarantee the outcome of the treatment
- That the patient or guardian is responsible for the payment of the treatment given

This form, when singed by the patient or guardian at registration or admission, becomes the consent record for routine investigations, medical treatment, diagnostic procedures and payment for the treatment.

The clerk at the registration counter must ensure that the patient or guardian has signed the consent form only after completely understanding its contents.

Consent for Release of Information

This consent is also printed at the back of the registration record. It states that the patient authorises the hospital authorities to release

information about his/her treatment to specified originations or people, such as the insurance company, the employer, etc. The signature of the patient on this form becomes the patient's consent for the release of his / her treatment information, thus authorising the hospital to release clinical data for specific purpose.

Special Consent

This type of consent or authorisation form is used when the patient has to undergo a major procedure or a non-routine investigation. This form, when singed by the patient, becomes the consent of the patient that he/she is agreeing to undergo the procedures listed in the consent form. This consent form is valid only when the consultant surgeon has explained the details about procedure, the risks, the alternatives and the outcome of this procedure, to the best understanding of the patient or guardian.

Clinical Data

The second major group of data in the medical record is the clinical data. It consists of the following records and reports.

- Face Sheet or Registration Form
    - It contains authorisation, consent for release of information, summary of the administrative and socio-demographic data, summary of the clinical data, which includes the final diagnosis and major and minor procedures. Against the final diagnosis, the relevant ICD codes are entered, using the International Statistical Classification of Diseases and Related Health Problems, or classification by ICD 10: volumes 1 and 3. The procedures are coded using the International Classification of Procedures in Medicine: volumes 1 and 2.
- History and physical examination chart
- Provisional diagnosis form
- Doctor's orders
- Progress notes
- Investigation chart

- This contains in compact form different laboratory and radiology investigation results. It is especially useful for patients with multiple test results and also for those who have to undergo repetitive tests. The results of a particular test can be compared over time and situations, for example, the blood sugar levels of a diabetic patient observed at different intervals on different days.

- Consultation request form
  - This is used for cross referral where the primary consultant of one speciality requests the attention and comments of another consultant of a different or related speciality, regarding the patient's illness, for example, a cardiologist referring to a cardiothoracic surgeon.
- Operation notes
- Anaesthesia report
- Postoperative orders
- Discharge summary
- TPR or clinical chart
  - This chart is used to record the temperature, blood pressure and respiration of a patient at regular intervals.
- Nurse's treatment chart
- Nurse's chart
- ICU notes
- Physiotherapy notes
- Medical Laboratory notes
- Medic-legal registration form(if it is a medico-legal case)
- Miscellaneous chart
  - This includes speciality forms, for example, neurological charts, C.T. post-operative charts, occupational therapy.
- **Miscellaneous notes**
  - **This includes correspondence**, referral letters
- Autopsy report (where applicable)

REQUIRED CHARACTERISTICS OF ENTRIES IN MEDICAL RECORDS

It is often said that a compete medical record indicates complete care and conversely, a poorly documented medical record reflects poor care. It may also be possible that a complete and meticulously maintained record exists for a patient who received poor care. However, the reverse is more likely to be true and a patient may have received good care which is poorly documented.

Appropriate Documentation

The information documented in the medical record by the medical professionals who are authorised and responsible to provide care, determines the quality of the medical record. The hospital management and the medical professionals of the hospital must determine the policy about who has the authority and responsibility of making entries in the medical record. The medical record must at all times contain enough information, which will enable the attending physician to given effective continuation of care and determine the condition of the patient at any given time. It should not only enable the physician to review the patient's condition, in order to give an opinion, but also to enable another physician to assume the patient's care at any time.

In addition to all the above functions, the medical record must have sufficient data for a review on utilisation and quality.

Authentication

Medical professionals who are authorised and responsible for providing care to patient care are also responsible for verifying and documenting the care given, in the medical record and authenticating the entry with the date of entry and signature. The identification and authentication can be a signature. The identification and authentication can be a signature, indefinable initials, or a signature affixed by a rubber stamp, if permitted most commonly used for pathologists and radiologists).

All physicians must authenticate every entry. A single signature in the initial history and physical examination and provisional diagnosis

form is not sufficient authentication of the complete record. In hospitals with resident or registrar staff, the primary physicians must countersign at least the history and physical examination and the discharge summary. All other parts of the record, which are the responsible of the primary physician, must be authenticated by him.

Abbreviations

Only standard abbreviations and symbols, which are approved the medical professionals, the ones for which explanatory legend is available with those who are responsible for entry in the medical record and also those who interpret them should be used. Every abbreviation or symbol used must have only on meaning. Abbreviations must never be used it the final diagnosis and must also be avoided in all entries in the progress sheets.

Timeliness

Human memory tends to fail, hence it is imperative that all documentation regarding patient care must be done as soon as the treatment or care is given. Records such as history and physical examination and laboratory and radiology reports are amongst those which must be written immediately and continuously from the time of admission to the time of discharge. The discharge summary may be written two or there days after discharge.

Completeness

The patient's record must be completed at least within a week of discharge. Completeness of medical records implies that all clinical events have been documented, as soon as possible after it took place and all the required forms and formats have been assembled and authenticated. The final diagnosis must be written without any abbreviations. All forms that need to be in the medical record for that particular admission must be completed and present in the record.

Legibility

The legibility of the documentation in the medical record determines the usefulness of the record. It is advisable that some of the forms in the record may be types. If feasible cost wise. For example, the

discharge summary, operation notes, radiology and laboratory reports, and such like can be typed.

Correction of Errors and Omissions

Correction of any error in the medical record is done by drawing a line through the erroneous entry with the citation, 'Wrong Record", beside it. The correct information must be documented immediately after striking out the wrong documentation and it must be authenticated with the signature and date, by the doctor who identified and corrected the error. The error must not be erased or painted with correction fluid. It any clinical event has not been documented through oversight, the entry should be made after the last entry, with and explanation regarding the omission and the reason for it being out of sequence.

FORMAT OF MEDICAL RECORDS

There are three common methods by which health records are arranged source-oriented medical records, integrated medical records and problem oriented medical records.

Source-Oriented Medical Record

This conventional method of arrangement is in use in the majority of hospitals. The record is divided in sections such as physician's notes, laboratory reports, nursing notes and so forth. Within each section entries are arranged in chronological order. Each section must be reviewed to obtain a compete impression of the patient's care and treatment

Integrated Medical Record

This method of arrangement is used in a limited number of health care institutions. Integrated medical records are arranged in strict chronological order, regardless of the source of the original information. Thus a physician's order may be followed by a consultation report or by a nursing note. This type of format provides a good account of the sequence of events but renders difficulty in the comparison and contrast of patient care information.

Problem-Oriented Medical Record (POMR)

This format, designed by Dr. Lawrence Weed several decades ago, places the major emphasis on specific patient problems. On admission to any health service or institution, each problem is listed and numbered, and from that time on all physicians' orders, progress notes, laboratory rests, treatment reports and so on, are correspondingly numbered and referenced to one of the problems on the problem list. SOAP is the acronym used to deal with each problem (S = Subjective data, O = Objective data, A = Assessment and P = Plan of action).

The POMR

The POMR is a chart format in which each patient who seeks care presets a list of active problems and physicians involved with that care must establish a plan of investigation, diagnosis, treatment and education of the patient for each problem. POMR is a unique approach to the practice of medicine enhancing a more comprehensive and a more structured care and treatment of the patient. In the words of Dr. Weed, "Without an organised, logical format to direct those who provide care, there cannot be adequate diagnosis and treatment".

- It makes patient data more useful by noting all problems.
- It unifies the data and prevents fragmentation of diagnostic and therapeutic information by making the patient the primary source of information by reflecting the patient's feelings, thoughts and ideas.
- It gives objectives and rules to the care given to the patient in order that the care may be judged.
- It allows for corrective feedback
- It makes the records more uniform, complete, relevant and less time consuming.
- It stops harmful action which may result from the treatment of two disparate diseases, thus makes the health team aware of the interdependence of social as well as medical problems.
- It enables the physicians to set priorities

- It helps elevate the medical record as a scientific document.

Advantages of the POMR

- It improves patient care
- It enumerates the patient's problem as single entitles, listing the diagnostic and therapeutic steps for each patient to the conclusion of each problem and thereby presents a total picture of each patient.
- It brings all patient problems into focus and indicates all treatment problems in relationship to each other
- It defines problems and utilises knowledge more effectively.
- It develops a logical structure which physicians utilise in defining and handling each problem and making it possible to follow each problem clearly and easily.
- It assures better communication between all members of the health care team, physicians, nurses and all paramedical personnel
- It permits any member of a heath care team to review a record of a patient transferred to his or her care and to assess past care in order to proceed with care in a logical manner.
- It standardises data in a uniform manner.
- It allows physicians to logically direct the health care team.
- It enhances the filed of epidemiology.
- It facilitates general health service planning.
- It facilitates individual health planning services
- It supplements medical education by encouraging sound logical thought about the patient and by makings ward rounds more relevant by enabling the physician to observe the patient's problems and improvement, as well as the student's progress.
- It allows students and their mentors to develop achievable goals and permits better control over the patient care environment by facilitating better use of their knowledge.

- It prepares physicians and other health care personnel for the modern computer era (the POMR is very compatible with computerisation).
- It makes accurate clinical research possible.

Database

Database contains a history of the present illness, administrative information, chief complaint, past medical and surgical history, family history, social history, patient profile (the patient's daily activities of living), review of systems – in explicit terms arranged in a logical manner, laboratory reports, x-ray reports and so forth. The database can be obtained manually o via computerised processing.

- The database must be defined
- The database must have uniformity without individual modification
- The initial collection must be as complete as possible
- The database must be known and followed
- Three is a minimal acceptable database (those disease situations which physicians cannot afford to overlook).

Problem List

Problem list is lists of problems disturb or endanger the health of the patient and requires further attention from the physician. The problem list is obtained from the database and sets the direction of patient care. The problem list includes

- Past problems (inactive) of previous significance that may occur again or lead to future complications
- Present problems (active) that care currently present including chronic conditions and diseases
- Possible or potential future problems encompassing concerns which are medical, psychiatric, social, physiologic, symptomatic, abnormal, preventive, demographic and so forth.

- Problem lists facilitate efficient resolution of all unsolved problems via
    - Inventory of problems
    - Maintenance of list
    - Communication among professionals
    - Statement of problems
    - Justification for treatment

Once a number is used on the problem lists, that number cannot be used again. The problem list must be complied at the level of current understanding of the problem (without unsubstantiated assumptions). Questionable or possible diagnoses and rule our conditions are not appropriate for this list under these guidelines. If a problem is multifactor, with separate management required for each component, these components are considered as individual problems. Problems should be categorised as either active or inactive.

Common errors in the development of the problem list include failure to list an obvious problem that is noted in the database, designating an abnormality to another problem presently encompassed on the list, construction of a cumbersome problem list due to failure to synthesize data, attributing new problems to old problems and neglecting to update and revise the problem list upon data collection.

Initial Plan – Patient Care Plan

A plan of treatment is developed for each problem as listed on the problem list. Numbers and titles on the initial plan must correspond to those on the treatment list. The initial plan establishes the character of future fat to be obtained and the focus of treatment to be given considering the entire spectrum of problems and thus avoiding premature conclusions or overlooking one problem in lieu of another. The initial plan should outline in detail the measures to be used in treating or preventing a problem. The patient care plan envelopes

- Plans for the collection of the data to establish or facilitate management of stated problems
- Plans for treatment with mention of specific procedures or drugs

- Plans for patient education concerning his or her illness and his or her role in its management
- Definite goals and objectives for the patient's hospitalisation

Common errors made in formulating the patient care plan include mixing plans and problems thus destroying the logical order of the plan, failure to specify plans for each individual diagnosis because a lengthy series of differential diagnoses may take the plan look exhaustive, failure to indicate a priority in diagnostic plans, failure or clearly specify therapeutic plans for each problem and neglect of patient education objectives in the desired outcome of treatment.

Progress Notes

Progress notes are the most crucial part of the Problem oriented medical record, for the progress notes chronicle the actions and results of the plans for each problem listed. Each problem must directly relate to a specific problem number and title. The parts of the progress notes are known by the acronym SOAP (Subjective, Objective, Assessment, Plan).

- Subjective – The patient's statement of complaint
- Objective – Physical or diagnostic information which is observable or measurable
- Assessment – Impression, interpretation, appraisal (without a good assessment a good plan cannot be formulated)
- Plan – Treatments and therapies as well as significant modifications of treatments and therapies with careful reference to the appropriate progress notes.

Proper use of progress notes allows all concerned with patient's care to comprehend the physician's appraisal of the problem and the physician's directives of care. Each progress note must contain all four elements delineated with appropriate labels. The assessment portion must be an analysis and not a repetition of the subjective and objective findings. All problems must be indicated on all progress notes a numbering must correspond with that of the problem list and with that of the initial plan (diagnostic, therapeutic and patient education). The

progress notes encompass the documented observations of not only the physician's but all members of the health care team including nurses, therapists, technicians and so on. Flow sheets, consultation reports, operative and procedural reports and discharge summaries are classified as progress notes in the problem oriented medical record system. Flow sheets present routine data in an abbreviated yet understandable manner which facilitates understanding. Each flow sheet is designed to encompass designated parameters for a given population. The discharge summary a retrospective noting of each problem listed on the problem list and treated during the current episode of care, providing a synopsis of the patient's progress toward the desired established goals as well as plans for continuity of care and follow-up.

The problem oriented medical record encourages comprehensive medical care in the context of a defined, consistent structure. The format demonstrates the development of logic and fosters an integrated team approach to medical care. The database enables continuity of care from inpatient to outpatient settings and eases the computerisation of medical records. Though the POMR, communication with the patient and all members of the health care team is enhanced; the system is goal-oriented, not task-oriented and thus better utilises the knowledge and training of both practitioners and researchers.

Record of the Future

Predictions indicate that eventually each individual will posses a computerised health record containing complete outpatient and inpatient data from birth to death (womb to tomb). Information gathered from various providers would be kept together as a single unit in a central data bank accessible from numerous sites.

Medical Records in Long-term Care

Each patient in a long-term care facility must have an individual patient record and the record should contain sociological information. The patient medical records should be simple, realistic and flexible but should be detailed enough to contribute to patient care and treatment. Events should be recorded in the order in which they occur. Such complete chronological recording justifies the diagnosis and proves that

the condition warrants the treatment and the end result/ the record should contain the current treatment information including the transfer and related medical information from previous health care settings, such as: Reasons for transfer, summary by referring physician, copy of previous hospital discharge summary or summation of patient's medical problems, diagnoses and physical examination.

The patient current record should contain admission, patient care and discharge plan: interdisciplinary plan reflecting each rehabilitation, alternative plans for maintenance of functional level if patient is placed for "balance of life" because he is no longer able to live independently, treatment, tests, medications, diet, resistant and restrictions, pharmacy consultation review of physician orders and medications given, progress notes: Physician, podiatrist, dentist, nursing staff, consultant and other professional personnel and discharge summary. All other speciality forms used in conventional care such consent, anaesthesia, operation, etc. have to be incorporated in the records.

Rehabilitation Records

Specialised rehabilitative services such as physical therapy, occupational therapy and speech therapy are provided upon physician's order. These services are provided to patient requiring assistance in returning to their maximum level of functioning. A written plan of rehabilitative care is entered in the patient's record based on the interdisciplinary patient care plan. Report on the patient's progress are communicated by the therapist to attending physician at appropriate intervals and made part of the permanent medical record.

Mental Health Records

Mental health records have to meet the long-term because of its unique characteristic nature of care and treatment. In the mental health care facility, the medical records generally contain the comprehensive general and psychiatry history, special consents for ECT, psychotherapy, occupational therapy record, social and psychological assessment records, psychiatrists pre-evaluation are regular progress assessments, consultation with other speciality and the treatment records including details about the medications and other records as used in other general

hospitals. The system of maintaining medical records is also same like any other acute hospital except the records are of very confidential nature and needs to be protected and evaluated thoroughly to ensure all the information collected are properly organised and assembled to enable the physician to have easy access of information for the future follow-up care.

The prisoners records which are of medico legal value have to the ensured their safety and completeness by the treating physicians. The MRO should ensure through the treating physician and nursing staff that the day-to-day care patient records are secured to prevent, damage destruction by the patients. The MRO pay special attention to ensure the records is complete in all patient care aspects to meet the legal requirements.

Content of Mental Health Records

According to the American Psychiatric Association, the mental health records should document the evaluation, treatment and course of the patient's illness. It also provides a means of communication between physician and other staff members contributing to the patient's care. The mental health record is also a basic source of information for study and evaluation o the care rendered. The mental health record should contain all pertinent clinical information, which at a minimum should consist of:

- Identification data
- Source of referral
- Reason for referral
- Patient's legal status
- All appropriate consents for admission, treatment, evaluation and after care
- Admitting psychiatric diagnosis
- Psychiatric history
- Record of the complete assessment, including the complaints of others regarding the patient as well as the patient's comments
- Medical history, report of physical examination and record of all mediation prescribed

- Provisional diagnoses based upon assessment which includes inter current diseases as well as the psychiatric diagnoses
- Written individualised treatment plan
- Documentation of the course of treatment and all evaluations and examinations
- Multidisciplinary progress notes related to the goals and objectives outlined in the treatment plan
- Appropriate documentation related to special treatment procedures
- Up-to-date treatment plan as a result of the contained assessment detailed in the progress notes
- Multidisciplinary case consultation notes which include date of consultation recommendations made and actions taken
- Information on any unusual occurrences such as: Treatment complications, accidents or injuries to the patient, morbidity, death of patient, procedures that place the patient at risk or cause unusual pain
- Correspondence related to the patient, morbidity, death of patient's treatment.
- Discharge or termination summary
- Plan for follow-up care and documentation of its implementation
- Individualised aftercare or post-treatment plan

ASSESSING THE PATIENT

Physical Assessment: It should include medical, alcohol and drug history and an appropriate laboratory work-up. In inpatient programs, a psychical examination must be completed within 24hrs of admission.

Emotional and Behavioural Assessment items to be included: These are history previous emotional, behavioural and substance abuse problems and treatment. Patient's current emotional and behavioural functioning, psychological assessment, when indicated and functional

evaluation of language, self care and social affective and visual motor functioning when indicated.

Social Assessment: It should include information related to the patient environment and home, religion, childhood history, occupational history, financial status, the social, peer group and environmental setting from which the patient comes and the patient's family circumstances including the family constellation and current living situation.

Recreational Assessment: Information relating to the patient skills, talents, aptitudes and interests.

Legal Assessment: It is unusual, but documented when the legal situation affects the patient care.

Vocational Assessment: It is not always conducted, but when appropriate it should include a vocational history, educational history which includes academic and vocational training and a discussion with the patient regarding his past work experiences, attitudes toward work and possibilities for future education, training and employment.

Nutritional Assessment: It is not always conducted, but when appropriate it should be documented. Patients being treated for eating disorders or patients having physical conditions which require special diets should have a nutritional assessment.

Other Assessments: In addition to the initial assessments just described, there are circumstances which arise during the course of the patient's treatment which require special assessment. Examples of these are:

- Prior to the implementation of seclusion
- Prior to the application of restraints
- Prior to the use of the electroconvulsive therapy
- After a therapeutic pass

USES AND IMPORTANCE OF MEDICAL RECORDS

The medical record contains wealth information and has several uses. The uses of medical records are of two major types, personal and impersonal.

Personal

Personal use refers to then the identity of the patient is need and retained, for example, a request for copies of specific portions of a patient's medical record by the insurance company for reimbursement claims. Insurance companies provide coverage for the patient's hospitalisation and thus, require specific information from the patient's medical record, in order to substantiate the claims made by the patient.

Impersonal

Impersonal use refers to when the patient's identity is not required and is therefore, not retained. For example, the use of data from a large number of medical records fro a research study or clinical trials. The reason for the medical record department to be concerned with such differences is because, for all impersonal use, authorisation by the patient, in the form of "consent for the release of information", needs to be taken before releasing by nay information to anyone from the patient's record.

The contents of the medical records can be used for education, research, public health and so on, where no reference is made to any particular individual and the patient's identification data is not revealed.

However, in supplying information to municipal or public health authorities regarding communicable and notifiable diseases, some personal information has to be divulged in public interest so that the authorities concerned can undertake appropriate public health measures. Normally, public health authorities are interested in impersonal information regarding the number of cases, deaths, births and so on.

Patient Care Management

The course of treatment given to the patient is documented fro every episode of care. This provides communication between the primary physician and other medical professionals treating the patient. The documented information in the medical record is also useful when subsequent care is provide to the patient.

Patient

It serves as a story of the patient's passage though hospital, maintaining continuity in that story. From this is extracted the information required by patient, e.g. a medical certificate of his or her hospital stay, diagnosis and so on. It saves time in avoidable investigations if patient is readmitted and may well influence the course of subsequent hospitalisation. Physicians now do not always have the time to get acquainted with the family life of a patient. For this reason, a written report of the family history and personal history are necessary. From an economic standpoint, use of medical record by other agencies representing insurance claims, union benefits, unemployment and industrial compensation is of paramount importance to the patient. Information contained in the medical records is often the determining factor in providing the patient with financial support or subsequent medical care for the remainder of his or her life.

The medical record contains vital information about the patient's past and present health history, the present episode of care documented in the form of history, physical examination and findings, diagnostics and the treatment given, either medical or surgical or both and the response of the patient to the treatment.

Over a period of time, medical professionals provide care to many patients and are not expected to remember the details about heath patient's illness, treatment and their response to the treatment. The patient also may not remember the significant details of this past illness and the treatment given. Thus, the record serves as a reference for both, the medical professional and the patient. It substantiates the care given to the patient and thus, helps in settling the patient's claim for reimbursement from the insurance company. It also provides vital information to the medical professional providing subsequent care or a different treatment to the patient, thus ensuring continuity of care. The medical record protects the legal interests of the patient in cases related to worker compensation, accidents and the Consumer Protection Act.

- Present and past state of health
- Analysis of present illness in terms of diagnosis and prognosis
- Consultation opinion

- Serves as reference
- Old records enable physician to review and analyse previous illness.
- Quick treatment – reducing the length of stay
- Allergies and drug reactions are noted
- Previous surgical procedures are recorded
- Protects surgical procedures are recorded
- Protects from over – prescription, unnecessary surgical exploration and repetition of investigations
- Protects from legal action
- Assist kith and kin in settling property litigation
- Obtaining blood group
- Obtaining medical certificates, such as birth, death insurance and so forth.
- It serves to document the story o the patient
- It serves to avoid omission and unnecessary and treatment measures
- It assist in the continuity of care in the event that future illness requires attention in or out of the hospital
- It serves as an evidence to support or to refute the legal questions that arise
- It assists the patient and the authorities concerned in fixing the disability entitlements under the Workman's Compensation Act.

Although the patient has got no legal right to the custody or perusal of his record, he/she may be given a brief summary of this condition, the results of various tests and types of treatment carried out in broad terms.

Relatives and Friends

No written information should be divulged to friends or relatives **who may be informed in the following cases.**

- **Condition of the patient – serious / very ill / satisfactory / progressing.**
- **Date of admission / discharge / death / birth of child.**

Physician

Medical record meets the physician's needs as:

- Practice of scientific medicine based on recorded facts.
- Continuity of medical care
- Evaluation of his or her own capabilities and shortcomings
- Effective communication for the medical team

If adequate in content, records when properly classified can be promptly retrieved for study and research. The progressive physician welcomes an opportunity to use such source material to survey the result of the treatment in a particular disease entity. Frequently a physician will wish to review all cases which he or she had in the hospital during a given time. The doctor may have a patient who does not remember details of a previous hospitalisation, he or she may ascertain what organ or organs were removed at the time of operation. Also, the physician or the hospital may need to refer to the record for medicolegal purpose.

The medical record provides information to the medical professional when treating the patient, guides him in deciding on the proper treatment to be given during the current episode and subsequent ones. It helps in providing continuity of care to the patient are different levels of health care. It also helps the medical professionals though case studies. Finally, it protects the legal interests of the medical professional.

- Yields information about previous treatment, reactions, allergies, drugs, investigations, methods of treatment and results of care.
- Suggests newer lines of investigations and treatment
- Evaluation of drugs for their clinical effect
- Information about availability of newer drugs for patients
- Comparative studies
- Medicolegal concerns
- Training and research

- It assures the doctor of the quality and adequacy of the diagnostic and therapeutic measures undertaken by him/her

- It assures the doctor of the continuity of medical care
- It protects the doctor in case of legal suits

Hospital

The hospital benefits as the records help in:

- Generating hospital statistics
- Teaching and research
- Admission control
- Planning of services
- Improving quality of care
- Safeguard in tort suits

Statistics gathered from medical records show to the hospital administrator whether or not the efforts of physicians supplemented by the hospital facilities are in accordance with reasonable expectation of modern scientific medicine. Liability suits involving hospital have been on the increase. Therefore, the hospital should be able to being before the court of law a compete, up-to-date medical record, fully documented, in regard to the patient's illness and treatment. Testimony based on recorded facts is given a greater consideration that testimony dependant on memory.

The medical record enables quality review – the performance of medical professionals working in the organisation is evaluated through regular review meetings based on the documentation in the medical record. It enables the hospital management to evaluate the usage of hospital resources, such as special diagnostic equipment and special services offered by the hospital and human resources. The medical record also protects the legal interests of the hospital in court cases, especially the ones under the Consumer Protection Act. Finally, it is useful for the hospital where financial reimbursement has to be made, in all cases where third-party payers are involved, such as company cases where credit facilities are available and insurance company cases. Specific detains from the medial records are provided to them to

substantiate the claims for the hospital for the care given to the patient. The record is sued by licensing, certifying and accrediting agencies for evaluation and for determining compliance with the standards of the respective agency.

- Evaluating the competency of the medical, nursing and ancillary staff (quality assurance)
- Justifying the results of treatment
- Medicolegal purposes
- Defence in malpractice suits
- Basis for preparing operating budgets
- Administrative control over functional activities
- Basis for distribution of expenses when computing cost of operation
- Statistical data to assist in controlling bed allocation, infection and mortality rates and length of stay.
- Planning of additional facilities, staff and equipment as well as improving medical education and patient care.
- It provides the management with statistical information necessary for decision making in regard to utilisation of resources, planning for administrative control and future references.
- It also furnishes documentary evidence for proposes of evaluation of hospital care in terms of quality, quantity and adequacy (Medical Audit).
- It protects the hospital in the event of legal questions (Torts Suits)

Education and Research

- Medical science is dynamic: New techniques, new methods and new medications
- Conduct research to meet own country's needs.
- Research results are shared by others.
- Each country has its own health problems.

- Medical records of present and past help in concurrent, prospective and retrospective research
- Learn simple and better ways to deal with problems
- Control health care costs
- Find better drugs and techniques
- Improve quality of services
- The teaching program
- Essential for medical education
- Medical students require lot of practical training besides theoretical chasses
- Clinical practice in art of history taking, proper physical examination and writing treatment notes
- Teacher is able to teach and guide better
- In the absence of teacher, student can learn techniques and methods of dealing with different classes.
- Learning traits of teacher through well-documented records
- Student learns from his mistakes
- Even senior staff learn from records
- Records are full of documented facts of live cases, which are better than a written textbook
- Undergraduates and postgraduates benefits.

National Health Agencies

- Depend on information
- Allocate budget, staff and equipment
- Plan and construct hospitals and health centres in required locations
- Determine the type of health services required
- Monitor all hospitals and health institutions
- Exchange expertise from other nations
- Collaborative with international organisations
- Develop medical and allied health service education

International Health Organisations

- Responsible for assisting and guiding nationals
- Control infectious diseases and epidemics
- Provide assistance to needy nations and accepting assistance from counties which have surpluses
- Exchange expert and specialities
- Send medical supplies and other items to needy countries
- Need reliable information from ali countries to achieve global healthier

Life Insurance Corporation of India

All of us are aware of the frequent requests that come from the Life Insurance Corporation regarding details of hospitalization of a patient. This is done with the purpose to dispose claims that have arisen for settlement as the patient is insured wit the Corporation.

We scan the Hospital Medical Records to gather the information necessary to complete the various Life Insurance Corporation forms.

Even though the information that is made available from the hospital Medical Records, it a privileged communication and the document in this respect is used as a personal document yet the decease of such information without the prior consent of the patient is permissible because the patient had waived his claim of this privilege at the time of taking out a policy with the Corporation. He has indicated this in a signed declaration which reads as follows.

"Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician from divulging any knowledge or information acquired by him in attending upon or examining a person. I my heirs, executors, administrators, and assigns or any other person or persons who shall have claim or interest of any kind whatsoever in the policy issued on the basis of the foregoing answers, hereby agree that any physician or medical attended who has attended upon or examined or treated me or who may here after attend, examine or treat me for any ailment or illness shall be at liberty to divulge any knowledge or information regarding my state of health

which he may have acquired whether before or after the policy is issued by the corporation to the corporation, its officers and legal advisor or in any Court of Law".

The Life Insurance Corporation (LIC) frequently request for details of hospitalisation and cause of death of the patient to dispose claims that arise out of the insurance policy. This information can be given to the LIC without the consent of the patient because he has waived his claim to this privilege by a singed declaration in the insurance policy.

Third-party Payers

Specific portions of information contained n the medical record is required by third-party payers, such as insurance companies or organisations responsible for hospital claim payments, in order to determine the eligibility of the care given to the patient and to substantiate the claims made by the patient or the hospital for financial reimbursement.

Press

No member of the hospital staff should give information to the press except the administrator himself / herself (confined to only date of admission / discharge / death).

In case the higher authorities fee that a press hand-out is necessary for public information, the ministry or the appropriate authorities usually ask for a brief condition of the patient from the hospital. The official spokesman may then issue suitable handout on the basis of the brief.

Public Health

The records are important to the public health authorities as they contain reliable information regarded morbidity and mortality patterns of dependant population. National and sate health laws require that certain reports be made available regularly to them. Reports like births and deaths, infectious diseases, notifiable diseases, statistics regarding incidence of diseases and types and number of family planning

procedures are constantly required by the government. Without the aid of medical records, this is not possible.

It is used for the identification of the incidence of infectious or other disease which helps in future planning for the overall health of the nation and the world. The medical record also provides vital statistics regarding the total number of births and deaths in the hospital to the public health agency in each state to revise the population count. In the interest of the individual and public health, it is imperative to provide information regarding the occurrence of certain diseases, such as communicable diseases and gunshot wounds, accidents etc. to the public agency of the state, so that proper precautions from data gathered in this manner from all public health agencies of different states will help in developing comprehensive health programmes at state and national levels.

Planning and Marketing

To identify the services for improving and promoting the different services of the hospital.

Legal Affairs

The medical record contains vital information which protects the legal interests of the patient, physician and the hospital.

Court of Law

According to the Indian Evidence Act, the hospital documents including medical records are admissible as documents of evidence because the entries in the documents are made by persons in the ordinary course of business or in the discharge of their normal professional duty.

The court can, therefore subpoena any document or record or summon the doctor for purpose of evidence in the court under the Law of Torts (liability for negligence).

The types of cases are

- Patient Vs Doctor suits
- Patient Vs Hospital suits

Medical records are frequently summoned to court in the following cases.

- Insurance cases
- Workmen's compensation
- Personal injury suits
- Malpractice suits
- Probate cases
- Notification of birth and death
- Criminal cases
- Medical reports and certificates
- Identification of patient and so forth

Police

As soon as a case is declared medico-legal, the medical officer is required by law to give a report to the police about the patient's injuries, irrespective of whether he/she is treated outdoor or indoor.

However, police should not be allowed to record the patient's statement without prior certification by the medical officer-in-charge that the patient is in a medically fit condition to do so.

In all the above cases, the hospital cannot be forced to produce or hand over the original record to the police, except by a subpoena by a court of law.

Group Study

- To issue case sheets to professors, associate professors lectures, pool officers, senior and junior residents or other consultants on demand
- To issue case sheets to sister incharge in case of readmission of the patient
- To make entries in the loan card (Alphabets)

- To make entries in the loan register and obtain signature. If a ship is sent by the medical officer, the same is to be filed in the authority file.
- To prepare the tracer card for taking out the case sheets
- To put issue number on the top of the case sheet for easy location when the same is returned
- To receive the case sheets in the loan register as well as from loan card when same is returned
- To issue clearance after through check-up from the loan card
- To prepare the reminders for the no return of case sheets
- To submit the name to medical superintendent if the same are not returned in spite or reminders, periodically.
- Dairy, despatch, circulation file.

Vital and Health Statistics

- Entry of birth reports in the birth register
- Sending births report to local municipality within 7 days with a covering letter
- Issue of birth certificate on request (on payment of designated fee)
- Amendment in birth certificate on the basis of hospital record only. An affidavit may be requested by the applicant for change in the record and that should be on a non judicial stamp paper and attested by the first class magistrate.
- A copy of an amendment should be sent to the local municipality
- Entry of death report in the death registers. Sending death report to the local municipal within 3 days with a covering letter
- Sending a copy of death certificate to local municipality with a covering letter
- Issue a duplicate copy of death certificate on request on payment of the designated fee by the applicant.

Correspondence

- Statistical data to be supplied to local municipality and directorate of health services on monthly basis and as and when data is required
- Correspondence for patient care, i.e. hospitalisation certificate, original or copy of the record required by other hospitals, record required by the court of law
- Receiving application for completing the medical attendant's certificate or certificate or hospital treatment by the treating physician in case of insurance polices and claims.
- To send the certificate after completion to insurance company with a copy of the covering letter to the party concerned
- The medical record of the patient is of confidential nature. No record or the contents there in should be given to anybody without medical superintendent's permission.

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UNIT II

MEDICAL RECORDS DEPARTMENT

FUNCTIONS

Primary function is the creation, care, storage, issue and retrieval of Medical Records.

Second function is the provision of statistical information for Medical, Administrative and other purposes.

Third function depending on the hospital, the operation of associated services concerned with the patient information system.

General Functions

The unit maintains, preserves, and microfilms old records as per the "record retention schedule", submits periodic reports, and prepares instructions on the proper maintenance of medical record forms, etc. This unit also trains employees and develops educational programs for departmental personnel. The medical record department also supervises the transcription of medical reports such as discharge summaries, operative reports, and other reports including pathology reports, radiology reports, medical histories and physical examinations.

Activities of Medical Records Department

- To initiate, process, and check the patient records from inpatient, outpatient, and emergency services to ensure that all the necessary forms and information are available.
- To cooperate with the medical, nursing, and other health care professionals in order to obtain comprehensive patient records and to design and develop effective medical record forms.
- To assemble medical records in accordance with the prescribed standard order.
- To code and index medical records as per international classifications of diseases and operations.

- To maintain and preserve **patient records** including X-rays and diagnostic reports in a scientific **way for the period** recommended in the "retention schedule".
- To retrieve medical records to meet the **needs of patient** care, medical education, medical training, medical **research,** medico legal problems, and the evaluation of patient care.
- To provide and maintain a system for transcription of selected medical reports.
- To control movement of patient files in order to achieve a unit record system, to protect files from unauthorized disclosure, to ensure confidentiality for the legal interests of the patient, the hospital, and the physician through proper custody of the records.
- To participate and cooperate with committees such as medical records, quality assurance, infection control, administrative, financial, and other committees.
- To carry out the work of central registration for initiating new patient records including the patient master index.
- To schedule and register follow-up appointment cases and referral cases in the outpatient department.
- To register and maintain records for emergency cases including medico legal cases in the accident and emergency department.
- To carry out admitting procedures for patients requiring hospitalization.
- To coordinate with other services related to those of the medical record department for effective filing and retrieval of patient records.
- To prepare and complete procedures related to medical reports, certificates, and birth and death reports, and to submit data to appropriate authorities.
- To register admitted and discharged cases in the ward registrar, schedule appointments for follow-up cases and to carry out the related ward clerk duties.

- To receive and preserve the patient's property in the admissions office in the absence of relatives who assume these responsibilities.
- To expedite the procedures of the department in accordance with the standards and rules established by the hospital.
- To develop and maintain an information base and mechanism for providing statistical data, and for submitting monthly reports concerning activities of the hospital and department, and for providing suggestions for effective functioning and future developments.
- To develop educational programs for the training of medical record personnel.
- To observe the ethics of the medical record profession and to strive for new innovations to improve departmental functions.
- To expedite any responsibilities related to the medical record department allocated by the chief of the medical record or central information department of the hospital.

OBJECTIVES

- To maintain a central system of complete medical records for every patient.
- To maintain indexes as to patients physicians', diseases, & surgical procedures.
- To prepare a daily census of patients.
- To prepare statistics of clinical work done & evaluate medical staff.
- To assemble scientific information from medical records & other sources for clinical study & research.
- To obtain patient' information from other hospitals & health care facilities.

- To prepare, for medical staff approval & issue certificates of patient's discharge for employees & insurance companies & birth & death certificates.
- To notify appropriate agencies of modifiable diseases.
- To file out - patients records separately in O.P. department or combine them with in patient's records & file centrally.
- To preserve old records in original state or on microfilm.
- To identify & file records, for e.g. Alphabetical or numerical.
- To issue a new registration no. Each time a patient is admitted or attends a clinic or to use the same first on. On each successive occasion.
- To decide the length of time to retain inactive records for legal & research purpose.

ASSEMBLING

The Medical Records Technician assembles the various forms in the following order.

- Identification and Summary sheet.
- Physician's discharge summary
- Transfer and referral statement
- History and physical Examination
- Patient care plan
- Orders
- Progress Notes
- Consultation Reports
- Nurse's Notes
- Special Rehabilitative Service Notes
- Laboratory and Radio Graphic Notes
- Discharge plan
- Miscellaneous papers (Medicare forms etc).

To assemble records in the following orders

- Face sheet, case summary and discharge records, history and physical examination, labour record, consultation record, laboratory and other investigation reports, anaesthesia record, operation record, nurse's record, temperature chart and OPD card.
- Tag the case sheets, keeping in view that the CR number is not missing while tagging
- To check the complete and incomplete case sheets. The compete case sheets to be filed in the proper filing area and incomplete case sheets be sent to doctor's room for completion. The incomplete records should be filed unit wise.
- **Submission of list for incomplete records to hospital administrator periodically.**

FILING

Rules and Procedures

Basic rules to aid in the efficient handling of M.R. include.

- When records are returned to the M.R.D. they should be sorted before being filed. This facilitates the finding of needed but unfilled records and makes refilling easier.
- Except for the faculty personnel who have been instructed to use the file are during unattended hours, only M.R.D Personnel should be authorized to handle records. During unattended hours, faculty personnel returning records should leave them at a designated place in the file are or M.R.D.
- Records with torn covers and those with loose papers should be repaired promptly to prevent further damage or loss of valuable information.
- An audit of the files must be made periodically to locate misfiled records and check requisitions which indicate records have no been returned.

- M. Rs involving legal actions should not be stored in the general files; these can be filed in a locked file cabinet in the M.R. director's office. Out guides should be placed in the permanent file to indicate that these records are in a special file.
- Filing area personnel should be responsible for keeping the shelves neat and orderly.
- Medical Records being processed or used by employees within the department should remain on desk tops or in specified files so they can be available at any time.
- Written procedures for filing are personnel are of assistance in their training and in maintaining control over the files.
- Records which are voluminous should be separated in two or more volumes but filed together in one location.
- Laboratory slips, X-rays and other "loose" or 'late' reports received in the department should be data stamped and sorted when received. Every effort must be taken to incorporate them into the records as soon as possible in the correct place of the records.
- The person supervising the file area should keep a report of activities in the area. Items includes in the report might include no. of requisitioned charts pulled each day, no. of emergency calls, and no. of records which could not be found. Counts such as these provide useful information for planning work and for controlling the area.

The main function of this unit is to collect records, X-rays, and to arrange them in a required order prior to filing them. This unit works around the clock, throughout the year, with three shifts in operation. The **patient records and** x-rays are filed according to terminal digit filing. This unit **also retrieves** records and x-rays for patient care, medical education, **medical research,** as well as other administrative purposes. There **are different types of filing** system namely, Straight Numeric, **Terminal Digit, Middle Digit, etc.**

Filing of Records in Appropriate Sequence and Manner

- Summary sheet
- History
- Physical examination
- Laboratory reports
- Physician's orders
- Progress notes
- Nurses records and charts
- Labour record
- Birth certificate
- Authority to operate
- Anaesthesia record
- Operation record
- Tissues report
- Death certificate
- Authority for autopsy
- Authority report
- Hospital infection report
- X-ray reports
- ECG reports
- Urology report
- Other graphic records and charts
- An other, if indicated

The medical record librarian separates records into 'complete' and incomplete' groups. Deficiencies are noted in an appropriate manner for which the committee can develop worksheets for use in recording review findings. All in complete records are reviewed by the whole committee which then forwards its comments and recommendations. The committee should periodically evaluate the entire record keeping function and should have the authority to approve new forms, delete obsolete forms, modify existing ones and suggest improvement in design for better record keeping functioning.

FILING SYSTEM

Centralised System

This is an arrangement in which all the case records of a patient, whether in-patient or out-patient are filed together within a central department. Under this system, both in-patient and out-patient records are filed together under one unit number.

Decentralised System

Under this system, the in-patient and out-patient departments have their own individual records and file theme independently within the departments. There is no connection between the two sets of files, if a patient is transferred from one department to another, the records can be seen only though a loan. This duplication of records increases the amount of labour and operating cost. For these reasons, this system is being rapidly replaced by the centralised system.

Decentralized filing results when certain parts of a record are filed I another location away from the central file area. In hospitals with may mean that the emergency record of a patient is filed in the out-patient area. This leaves only the in-patient records in a central file. Even when an unit is made of several in-patient admissions for a patient, the files are considered decentralised if the out-patient or emergency room records are filed separately.

Advantages

- Decentralized filing is good when out-patients are being seen frequently. So it is more efficient to store the records in the O.P. area.
- When a health care faculty operates from several sites this system requires less transportation, time and effort.

The type of Numbering, the method of filing & the system of filing are very important for determining the space required for a M.R.D.

Straight Numerical Filing

This system refers to the filing of records in exact chronological order according to M.R. No. Therefore the numbered records would be filed in consecutive order on a shelf.

In straight numeric method of filing system, all records should be filed in the strict numerical order. It is one of the easiest methods of filing system and even the new medical record staff can get acquainted with this system of filing system easily. But the disadvantages of tracing mis-filed records will consume lot of time, and the records will be added to one end of the filing rack, by which the equal distribution of work will be difficult.

Advantages

- It is simple to pull any no. of consecutively number records.
- The greatest advantage of this type is the ease with which personnel are trained to work with it.

Disadvantages

- No. of digits must be considered, so there is chances of misfiling. The greater the no. of digits, the greater chances of error during filing.
- More filing activity is there in the place were the new records are filed.
- Several clerks filing records at the same time in the same area are bound to get in each other's way.
- Quality control of filing is difficult. You cannot give one section to one clerk. Therefore it is difficult to give work distribution to workers.

Alphabetical Filing

As the term itself tells the files are arranged in an alphabetical order according to the patient's name.

Disadvantages

- There are possibilities of spelling mistakes due to pronunciation.

- In case of patients having similar name there will be problems in identifying the records when other terms like the patients age, father's name, address have to be considered.

Middle Digit Filing

In middle digit filing, the clerk files according to pairs of digits as in the terminal digit method. However, the primary, secondary, and tertiary digits are in different positions. The middle pair of digits in a six-digit number is the primary digits; the digits on the left are the secondary digits; and the digits on the right are the tertiary digits.

46	88	86
Secondary	Primary	Tertiary

Shown below are sample sequences from a middle digit file:

46-68-96	99-68-96
46-68-97	99-68-97
46-68-98	99-68-98
46-68-99	99-68-99
47-68-00	00-69-00
47-68-01	00-69-01
47-68-02	00-69-02

The block of 100 charts would be filed in straight numerical order.

Advantages

- Simple to pull up to 100 consecutively numbered charts for study purposes.
- Conversion from a straight numerical system to a middle digit system is much simpler than conversion to a terminal digit system.

- Middle digit filing provides a more even distribution of records than straight numerical filing, although it does not equal the balance achieved by a terminal digit filing system.
- Clerk may be assigned responsibility for certain middle digit sections. As in terminal digit filing, the clerk is filing by pairs of digits rather than six or seven digits; therefore, miss-files are reduced.

Disadvantages

- More training is needed for this system than Terminal or Straight Numerical filing.
- Gaps result in the file when large records are pulled for inactive storage.
- It is not useful for numbers more than 6 digits.

Terminal Digit Filing

This is a simple and accurate filing method which increases productivity of file clerks. The clerks file the records according to the Terminal digits (i.e.) last two numbers are noted and the files containing similar last two numbers are kept together in the same rack. For each terminal digit there is a separate rack. The numbering is from 1 to 100. Therefore there must be 100 cabins to keep the folders. Each clerk is given different filing areas.

Terminal digit filing is a simple and accurate filing method, which increases productivity of file clerks. Usually a six-digit number is used and divided with a hyphen into three parts, each part normally containing two digits. The primary digits are the last two digits on the right hand side of the number. The secondary digits are the middle two, and the tertiary digits are the first two on the left side of the number.

In terminal digit·file, there are 100 primary selections, ranging from 00 to 99. When filing, a clerk considers the primary digits first, taking the record to the corresponding primary section. Within each primary section, groups of records are matched according to secondary

digits. After locating the correct secondary digit section, the clerk files in numerical order by the terminal digits. In the file, the second tertiary digit changes with every record. Note the following sequence in a terminal digit file.

56-46-96	98-46-96	98-99-96
57-46-96	99-46-96	99-99-96
58-46-96	00-47-96	00-00-97
59-46-96	01-47-96	01-00-97
60-46-96	02-47-96	02-00-97

Advantages

- As new records are added to file, their terminal digit numbers are equally distributed throughout the 100 primary sections.
- Only every 100th new medical record will be filed in the same primary section of the file. The implications of the "Perfect" distribution is extensive.
- The congestion that results when several clerks file active records in the same area of the file are eliminated.
- Clerks may be assigned responsibility of certain sections of file.
- As the registration numbers are still assigned in straight numerical order, the work is evenly distributed with each clerk having approximately the same number of active records in each section.
- Inactive records may be pulled from each terminal digit section as new records are added.
- Mis-files are substantially reduced with the use of terminal digit filing. Since the clerk is concerned with only one pair of digits at a time, the transposition of numbers is less likely to occur.

Disadvantages

- More units of shelving may also be required initially, since expansion must be planned by equipping the total file are from the start. Therefore investment is more at first.

Numbering System

The Numbering system used on the records plays an important role in filing medical records. There are 3 types of numbering systems.

Unit Numbering System

In this system the patient is assigned a number on the 1st admission or visit which is retained for all subsequent admission & treatment, throughout his life time.

Advantages

- It provides a complete picture of the patient's medical history & therapy.
- It eliminates the task of gathering separate parts of a patient's record.
- To maintain a unit record, some form of binding all parts is necessary. A fastener with two prongs may be used in tabbing.

Disadvantages

- The records documented on multiple occasions of treatment may become so thick that additional folders may be needed to house one complete M.R. Therefore each folder should be marked with both volume number & the total number of volumes.
- When choosing this system it is necessary to leave 25% of the shelves open because additional room is needed to allow for expansion of individual M.R.

Serial Numbering System

In this system the patient receives a new no. for each occasion of treatment by a health care centre. If a patient is registered 3 times, 3 different numbers are assigned.

Disadvantages

- Because a new no. is issued for each occasion of service, a new M.R. is developed. Therefore the patient's medical records are filed in as many places in the filing areas the no. of times the patient has received care at the hospital & given another number.
- It is hard to trace the folders. This system does not exist now.

Serial Unit Numbering

Each time the patient is registered, a new hospital no. is assigned; but the previous records are continually brought forward & filed under the latest no. issued. When the older records are brought forward, an out -guide must be left in the file where the old records are pulled to indicate the new no. under which the record is now filed. The empty chart folder marked with a referral to the new no. is also an out -guide.

Disadvantages

- In this system M.R. moves forward, gaps may occur on the shelves as records are pulled. This is more in the case of high re-admission rates.
- This system is not possible.

METHODS OF FILING

The modern methods of filing can be classified into the two following categories:

Horizontal Filing

Under this method, the papers are inserted in files or folders and the folders are kept in horizontal position one upon each other and these are maintained in chronological order.

Vertical Filing

This is the most modern method of filing, in which the files are placed vertically or in a standing upright position

This method has the following advantages

- Facility for ready reference
- Economy
- Scope for expansion
- Adaptability
- Safety of papers
- Wide applicability

CODING

The clerk in-charge of this section will code all the diagnostic and operational procedures given in the case sheet of each patient according to the International Classification of Diseases Book Vol I and Vol II.

International classification of Procedures in Medicine

Volume I - Contains Procedure for Medical; Laboratory procedures; Preventive Procedures; Surgical Procedures; Other therapeutic Procedures; Ancillary Procedures.

International Classification of Procedures in Medicine

Volume II - Contains Radiology and certain other applications of physics in medicine; Drugs, Medicaments and Biological Agents.

Advantages of Coding

- Instead of entering the whole detail of diagnosis the code no. helps to reduce the work.
- Similar code nos. can be easily sorted out for study and research of a particular disease.
- It also quickens the work of preparing statistics for a particular disease.

Coding

- Classifying the record of inpatient by diseases using ICD coding system
- Coding to provisional diagnosis (at the time of admission)
- Coding to death certificate

Colour-Coding of the Record Folders

Color –coding refers to the use of color on folders to aid in the prevention of mis- files and in the location of filed-filed records. Color bars in various positions around the edges of folders (known as blocking) create distant patterns of color in various sections of the file. A break in the color pattern in a file section signals a filed-filed record. Color-coding is most effective when used in conjunction with terminal digit and middle digit filing, although workable color-coding systems can be used for straight numerical filing.

One approach to color-coding in a terminals digit or middle digit file utilizes ten different colors to signify the first primary digits 0 through 9. Two color bars or blocks appearing in the same position can be used to

Signify each of the two primary digits. In this case the top colour bar represents the left hand digit of the primary set, and the bottom color bar represents the right hand digit of the primary set. If brown is the color assigned to the digit 8 and green is the color assigned to the digit 4, a chart numbered 1694 84 in a terminal digit file is color coded with a brown band on top, with a green band directly beneath it.

Two Digit Primary Nos.	*One Digit Primary Nos.*	*Coloured Bands*
00-09	0	Purple
10-19	1	Yellow
20-29	2	Dark green
30-39	3	Orange
40-49	4	Light blue
50-59	5	Brown
60-69	6	Cerise
70-79	7	Light green
80-89	8	Red
90-99	9	Dark blue

Coloured Files

Uses of files of different colours for different years is useful for easy identification and retrieval

INDEXING

Preparation of Disease and Operation Indexes are important in a Medical records department. A disease index lists diseases and conditions according to the classification (coding) system used by the faculty. A listing of surgical and procedural code Nos. comprises the operation index.

This includes the following type of indexes:

- Patient index (Alphabetical index)
- Disease index
- Doctor index
- Unit index
- Operation index

Content of the Index Card

1. Medical Record Number	7. Disease/Operation code
2. Name of the patient	8. Date of Admission
3. Religion	9. Date of discharge
4. Age and Sex	10. Hospital days
5. Result	11. Service
6. Other code	12. Physician/surgeons name.

Uses of Indexing

- To review previous cases of a given disease in order to provide insight into the management of a current patient's health problems.
- To test theories and compare data on certain diseases and for treatments in order to conduct research and prepare scientific papers.
- To procure data on the utilization of facilities and to establish a hospitals need for new equipment, beds, staff etc. in various departments.
- To evaluate the quality of care in the hospital.
- To conduct epidemiologic and infection - control studies.

- To accumulate risk management data, such as the incidence of medical and surgical complications.
- Providing patient care data required for licensing and accreditation surveys.
- Providing data on medical practice in the facility in order to qualify for accredited internship and residency programs.
- Determining whether the treatment and procedures provided were necessary and appropriate for the diagnosis.
- Providing educational materials for students and medical staff meetings.

Patients Alphabetical Index

The Patients Alpha Index serves as the backbone of M.R.D. in the absence of computers. This serves as a key for locating the medical records of all patients.

When a patient is admitted or treated an Alpha Index card, with particulars like name, age, sex, father's name, religion, address, attended unit, date of admission, date or discharge and diagnosis is prepared. These cards are arranged alphabetically in the "Kary-Veyor machine".

When the patient is admitted, the Alpha Index card of the patient is pulled out from the Kary-Veyor machine and kept in the "House Cabinet" which will show the exact is discharged, the card is removed and put in the Kary-Veyor machine in alphabetical order.

Patient Index

- Sort out the cards in alphabetical order
- File in the patient index cabinet strictly in alphabetical order
- Take help of this index if the CR number has to be found out only by name. Sometimes the patient does not remember the date of admission in the hospital.

Indexing (Diagnostic)

- Indexing of all cases with multiple code numbers

- Put the year and code number on the top of the card-used, the first card as A1 back A2 and so on.
- Make entries of CR number, age and sex, complication, unit, duration of stay. The complication is to be crossed just after the CR numbers, so that the cases of final diagnosis can be known easily.
- Complications of provisional diagnosis in code numbers, later on monthly basis

Basic Records

- Summary sheet or face sheet: It is the top sheet of the medical records and contains the patient's identification data, social data, provisional diagnosis, final diagnosis, name of the physician, date and time of admission and discharge, and signature of the physician.
- Admission record card: This should show the following information:
  - The full name, address, nationality, age, marital status, religion, and occupation of the patient,
  - Name, address, phone number of the nearest relative or friend and of the attending physician.
  - Name of the father/guardian and his/her address.
  - Name, address, and phone number of the employer.
- Authorization of medical/surgical treatment.
- Discharge summary.
- History.
- Physical examination.
- Laboratory reports.
- Progress notes.
- Physician's order.
- Graphic chart
- Nurse's **bedside record.**

Special Records

These include reports of consultation, transfusion, anaesthesia, tissue reports, ECG, X-ray, short-stay reports, obstetrical records, new-born records, records of progressive care units, autopsy records, consent forms for surgical intervention, abortions, and operation. Other special records can include death certificates, correspondence, birth certificate, etc.

DEFICIENCY CHECK

Here the records must be checked for completion. The Medical Records must be checked and contents analysed for completeness, accuracy, and adequacy by the M.R.T. Each day's work must be entered in the deficient check diary which must be signed by the M.R.O.

The deficiencies are noted in a slip and attached to the concerned M.R. These deficient files are left in the deficient racks. The M.O. goes once in a week to complete the deficient records. Thus, the incomplete records are completed as that the Medical Records contain sufficient data written in sequence of events to justify the diagnosis and help in the treatment. Thus the Medical Records are quantitatively analysed by the M.R.D. Personnel and Qualitatively analysed by the Medical Officers.

Discharge Analysis

Here the case sheets of all patients are analysed and various administrative statistics are prepared (1) No. of patients admitted (2) discharges (3) deaths ( ) births (5) maximum no. of patients treated per day. (6) no. of patients expired within 24 hrs and 48 hrs etc. are prepared.

The following registers must be maintained here:

1. Discharge analysis register
2. Consolidatory discharge analysis register
3. Unit wise against medical advice discharge.
4. Unit wise hospital days for the month.
5. Age wise distribution of discharged/Dead patients.

Other Registers which must be maintained by the M.R.D.

1. Patient Admission Register	6. Corporation Register
2. Discharge Register	7. Census Register
3. Birth Register	8. Operating Room Register
4. Death Register	9. Emergency Register
5. Accession Register	

RETRIEVAL

Routine requests for records, as from O.P. areas or for study and research purposes, should be delivered to the M.R.D by a specified time of day established by hospital policy. Therefore it is necessary to have a requisition slip. Which is usually three -part form. The main amount of information which must be include on the slip is the patient's name and M.R. No. the name of the requisitioning patient care area or person and the date on which the record is needed.

One copy of the requisition is fastened to the M.R. when it is pulled from the file. This copy serves to route the record. Another copy becomes the sign-out which is placed I an out - guide and filed to replace the pulled record. The out - guide and sign-out are removed from the file when the record is returned. Still another copy of the requisition may be retained in the M.R.D. as a reference to those records which have been sent to other areas of the faculty and not yet returned.

A small card file box may be used to house the location slips for all patient records removed from the department. in hospitals which have, when the M.R. is returned the requisition slip is removed from the location file and destroyed. if the M.R. is not returned within the established time, the locator file provides a ready reference for reminding the requestor to return promptly to M.R.D. In large institutions the locator file maintained in a computerized record tracing system.

Out-guides

Out guides provide an imp. means of control over record usage. They are used to replace a record that has been removed from the files. The guides remain in the file until the borrowed record is returned and refiled.

Locating Misfiles

Various techniques for locating a misfiled record are:

- Look for transposition within each set of two digits of the number. E.g. the number 46-73-82 may be filed as 46-37-28 or 46-73-82.
- Look for misfiles of '3' under '5' or '8' and vice verse as these numbers may look similar, and of '7' or '8' under '9' especially as covers become worn.
- Check for a certain number in the 100 group just preceding or following the number, as 484 under 385 or 585, or under similar combinations.
- Check for transpositions of 1st and last numbers.
- Check the record just before and just after the one needed. it sometimes happens that a record is put into another cover rather than between two covers.
- Check immediately above and below where the record should be filed as a distraction during filing may have resulted in misplacement.

RETENTION

The length of time a medical record is to be retained should be determined by the existing law. However, there is no law in India which specifies such a period. In the absence of such regulatory requirement, the hospital administration will have to establish its own policy governing retention. Theoretically, hospitals should retain records for as long as there is a medical or administrative need for them, e.g. subsequent patient care, medical research, review and evaluation of

professional and hospital services or defence of professional or other liability actions.

Apart from the above factors, the hospital should also consider the storage capabilities. The retention periods have been endlessly debated in various forums with some clinicians wanting to retain them up to 20 years.

Some of the senior medical records officers consider it desirable to retain them as under:

- Need of patient : Up to 7 years
- Medicolegal : Inpatient – 7 years / Outpatient – 5 years
- Teaching / Research : Up to 7 years

It is seldom that records older than 7 years have been required to be retained. The American Medical Records Association has adopted a policy of retaining a record for a period of ten years.

Keeping records for such long periods consumes a lot of space. The two alternatives to retaining bulky medical records are:

- Microfilming
- Comprehensive summary

As long as information is retained, it is subject to use and abuse. The product facility holding health information will recognize the link between retention schedules and confidentiality of information. All facilities should establish a retention schedule that first takes into account mandatory state statutes. Beyond those standards, or their absence, the retention schedule should be developed by answering practical questions:

- Who will retain each type of record data?
- What data are to be retained and in what form?
- Where are the data to be retained?
- Why are the data to be retained?
- In what format are the data to be retained?
- How long are the data to be retained?
- How will the data be destroyed?

Inactivity

To decide on the inactivity of a case record, the following factors should be taken into consideration.

- The total space available for filing
- The yearly expansion rate, based on the inflow and the space occupied by them, when arranged on the racks

Destruction

When planning for the destruction of the files, the following factors are important.

- Extent and intensity of research conducted
- Laws and statutes of the sate in which the facility is located, that might limit the destruction of specific files
- Extent of review and readmission cases
- Cost involved in storing inactive files
- Cost involved in destruction of files

Options

Some of the options for storage or destruction of inactive records are

- Storing in another areas of the hospital
- Resorting to commercial storage
- Microfilming of records
- Storage on magnetic disks, optical media or CD-ROMs
- Destroying the records through the incinerator or with a shedder

STORAGE

From retention schedule, it is clear that some of the medical records have to be retained for more than 10 years and some of them for even an indefinite period because of the important purposes they serve, namely

- To meet the need of patient.

- To assist in protecting the legal interest of the patient, the attending staff and the hospital and also to serve as proof of work done.
- To assist in the teaching of medical and paramedical staff and to carry out medical research.

The following measures are recommended for proper preservation of medical records.

- **Selection of Paper & Ink**: For the record to be preserved either for longer duration, say for more than 10 years or meant for lasting permanently, selection of paper and ink plays an important role. Many countries like the USA & the UK have developed specification of paper and ink expected to last permanently. The ISI has laid down 15:1774-1961 as specification for paper and 15:221-1962 (revised) for writing ink for permanent records.
- **Preservation of Decay and Rot** Deterioration of records takes place if they are exposed to hot and dry climate, stagnant air, direct sunlight or heat, accumulation of dust and dampness. As such arrangement for proper cross- ventilation and provision for an adequate number of electric fans / air conditioners and exhaust fans should be made to ensure good air circulation. Regular dusting of records with the help of vacuum cleaners is also necessary to keep them clean and tidy.
- **Protection from Insect Attack** Dark and dingy places, crevices, crack, loose joints in floor and walls and presence of edible in the record room encourage insect breeding. Along with periodical checking of the floors, walls, and attending to minor defects, insecticidal powders or spray insecticides can be used and naphthalene balls placed on book shelves to prevent infestation of records by insects. While using liquids care should be taken to see that records on shelves are not directly sprayed upon, as the liquid might stain or damage the records. For fumigation of record rooms only those fumigants, which do not have any deleterious effect on paper and other record materials, should be used. Filing racks should not be kept in close contact with damp walls to avoid damage by damp and silverfish. The rack should be installed at

least 5" away from the wall. Since wooden shelves attract white ants skeleton or closed steel rack are preferred for filing medical records.

- **Atmospheric Pollution:** (acidic gases & dust) It has been observed that the records and registers deteriorate more rapidly in a city than in its suburbs due to the presence of acidic gases in the atmosphere, especially, sulphur-di-oxide & sulfurated hydrogen in the polluted air of industrial zones. Dust particles present on paper, act as nuclei for the condensation of acidic gases and propagation of mildew spores and lead to growth of mildew.

- **Safety Measures Against Fire in Records Room**: Smoking, lighting of match stick or carrying of an open flame and storage of chemicals in a record room should be prohibited and adequate fire extinguishers should be fixed at convenient places. All electric wires should run through conduits. Windows & ventilators should be covered with wire-net frames as safe guard against sabotage or pilferage.

- **Temperature and Humidity Control**: Temperature and relative humidity of the atmosphere above 32°C (90°F) and 70% respectively result in the growth and propagation of pests like hookworms, silverfish, cockroaches, termites and variety of fungus commonly known as mildew. Temperature and relative humidity most suitable for proper preservation of paper and other record materials range between 22-25°C(72-78°F) and 45 –55% respectively. Regulation of Temperature and humidity in the above range is only possible with the help of an elaborate air conditioning plant. In a air conditioning system it is also possible to treat the air with alkaline water having a pH of 8.6 or above, so that acidic gas in the atmosphere may be neutralised. Heavy dust particles are also eliminated in the airway system. Direct sunlight is regarded as an enemy of records. De-humidification by de hydrating chemicals or commercial humidifiers can be used for reducing humidity in the room.

- **Care in Handling**: All endeavours for proper preservation and storage will however be in vain if care is not observed in handling

the record. This is often conspicuous by absence in our libraries and record rooms.

- **Micro Filming Control Register**: As per the record retention schedule, certain medical records including patient files must be preserved and microfilmed. Therefore, maintaining a microfilming control register in order to have a good account of the records microfilmed is essential. As a long-term measure, the following two methods are suggested. Maintaining a microfilm pre-hospital number register with the following columns: Hospital number, patients name, age, sex, date last admitted, date microfilmed, microfilm file number, date original record destroyed, and other pertinent remarks. Pre numbered microfilm sheets contain 0 – 100 numbers. For example, a record with the hospital number (39821) is microfilmed. In such instance, a mark (dot) should be placed in an appropriate place, i.e. a number which contains the hospital numbers from 39801 to 39900.

* * *

UNIT III

OTHER SERVICES

OUT-PATIENT DEPARTMENT

Whenever a patient comes for treatment, the patient approaches the O.P. Clerk and the clerk issue an O.P. Chit. Thereafter a Medical Record is opened for each patient and the patient is directed to consult a Medical Officer. The Medical Officer records the statements from the patient and the treatment given to him. Thereafter, the Medical Officer retains the Medical Record with him, and the patient is given the O.P. Chit with the medicines prescribed. Then the Medical Officer's Secretary returns the M.R. to the M.R.D. The filling clerk files the records.

The outpatient medical record services are classified into two sections:

- Central Registration and Appointment: This section functions around the clock throughout the year with three shifts in operation. The personnel employed in this service perform the following functions:
  - Control of hospital numbers
  - Preparation of prenumbered folders
  - Registration of new cases
  - Maintenance of patient master index
  - Registration of follow-up appointment cases
  - Supply of records to outpatient clinics
- Outpatient clinic: The medical record staff posted in
  - This unit performs the following functions:
  - Collection of new and follow-up registered patient records including x-rays
  - Maintenance of accounts of patients treated in the clinic
  - Maintenance of accounts of patients referred to and received from other clinics, investigations, and admissions
  - Collection and return of records to the medical record files.

IN-PATIENT DEPARTMENT

The patient goes to the O.P.D. and consults the Medical Officer, and if necessary the Medical Officer advices the patient for admission.

The inpatient medical record services are classified into two sections:

- Admission Office: This office functions around the clock throughout the year. Staffs are posted in three shifts to perform the following functions. In small hospitals, the work of the third shift can be transferred to casualty section.
  - Maintenance of waiting list of patients
  - Registration of admissions and discharges
  - Maintenance of the bed occupancy board
  - Secures patient property
- Ward: The work relating to medical records in the ward will be performed by the ward nurse, or ward clerk (AMRT). The following are the main functions:
  - Registration of admissions and discharges
  - Receipt and mounting of investigation reports in the appropriate records
  - Maintenance of accounts of bed position
  - Scheduling of appointments for follow-up cases
  - Preparation and submission of ward daily census reports

ADMISSION COUNTER

As advised by the Medical Officer, the patient approaches the Admission counter and the clerk clarifies with him about his old attendance. The enters the particulars of the patient regarding Name, age, sex, address, occupation, salary and his symptoms in the admission register and in the Accession register and case sheet. Then the patient is sent to the concerned unit as In-patient. The Duty Assistant Physician enters in the case sheet about the physical examination and condition of the patient and admits him in the ward. The Duty Assistant Physician also enters.

- The Provisional diagnosis
- Positive findings
- X-ray reports
- Lab reports
- Progress Reports
- Operation performed and post-operative report
- Discharge order
- Final diagnosis
- Conditions and discharge, in the MRs.

As soon as a patient is discharged or expires. The Medical Records are brought to the M.R.D.

In the M.R.D. the records pass trough the following sections. (1) Assembling (2) Deficiency check (3) Discharge Analysis (4) Coding (5) Indexing (6) Patient's Alpha Index (7) Computers (if there is) (8) Filing and Retrieval.

LABORATORY SERVICES

- Requests for laboratory tests should be documented in duplicate in the appropriate prescribed form with the required identification informed.
- It is the responsibility of the laboratory to maintain a proper recording system whereby all requests received are accounted for and all reports are dispatched promptly to the concerned people.
- If the report is prepared on a separate form (other than the request form), it is the responsibility of the laboratory to record properly the identification information.
- Reports should be prepared in duplicate. The original copy becomes part of patients file and the duplicate copy is retained in the laboratory for departmental reference.

- Each laboratory maintains its own numbering system called "the laboratory (pathology) number" starting from 00 00 01 and continuing to 99 99 99
- There should be a cross reference register with hospital numbers to indicate that the numbers of diagnostic investigations carried out on different occasions for a particular patient are entered against the appropriate hospital number. This procedure expedites the referral of reports of previous diagnostic investigations carried out on the same patient
- Duplicate copies of the reports should be retained as per the " record retention schedule" of the hospital
- Old records including reports, registers, index cards, etc., maintained in the laboratory department should be sent to the Medical Record Department for preservation and destruction according to the "record retention schedule".
- The laboratory should submit a monthly report in prescribed form to the administration and the medical record department.

RADIOLOGY SERVICE

- X-ray requests should be documented in triplicate in a prescribed form with the required identification information included.
- It is the responsibility of the radiology department to maintain a proper recording system whereby all requests received are accounted for and all reports are dispatched promptly to the appropriate people.
- If a report is prepared on a separate form (other than the request form), it is the responsibility of the radiology department to properly record the patient identification information.
- Reports should be prepared in triplicate. The original copy is sent to the medical record department or to the ward to be mounted in the patient file, the second copy is placed in the x-ray jacket and the last copy is retained in the radiology department.
- The radiology department has its own number called the "X-ray number" starting with 00 00 01 and continuing 99 99 99

- There should be a cross reference register maintained with hospital numbers indicating the number and type of X-ray films taken on different occasions for a particular patient corresponding with the appropriate hospital number. This procedure facilitates referral to all x-rays previously taken for the same patient.
- X-rays of both outpatients and inpatients are filed in a terminal digit filing system. X-rays of accident and emergency (casualty) department patients are filed according to the serial numerical order.
- X-ray films should be preserved in either the radiology department or the medical record department as per the "record retention schedule"
- Duplicate copies of the reports should be retained according to the "record retention schedule".
- Old records, reports, registers, index card, etc. maintained in the radiology department should be sent to the medical record department for preservation or destruction in accordance with the record retention schedule.
- The radiology department should submit a monthly report in the prescribed form to the administration and the medical record department.

PHARMACY SERVICE

- The pharmacy must ensure that drugs are dispensed to patients only when the prescribed pharmacy form, duly numbered, and signed by an authorized medical officer is submitted.
- Drugs to inpatients are supplied as per the prescribed inpatient drug sheet.
- The pharmacy department should submit a monthly report to the administration and the medical record department.

CONTROL OF MOVEMENT OF RECORDS

All the patient medical files of emergency patients, outpatients, and inpatients are kept in the medical record department under the

custody of the medical record staff. The following procedure is recommended for movement of patient records.

Emergency Records

Accident and emergency form which was initiated and sent to the casualty medical officer for treatment must be collected immediately after care of the patient and retained in the allocated section within the medical record department. Patient files are not to be retained by any individual without the express knowledge and consent of the medical record department. For admitted cases, the inpatient procedure is applicable.

Table showing the responsibilities of the content and maintenance of the medical records

Clinical Transaction	Caregivers	Documents
Admission Process personnel, Nursing personnel Initial assessment • History & Physical • Sociological	Admission & registration • Medical & nursing personnel • Social worker	Patient identification consents • History & physical exam • Social service assessment
Clinical Laboratory Studies	Medical technologist, pathologist	Clinical pathology reports
Radiological reports	Radiologist, radiology technician	Radiology reports
Consultations	Medical specialities(medical, surgical, obstetrics, paediatrics, nutritionist, psychiatrics, psychologist)	Consultation report

Orders for diagnosis and treatment	Physician attending medical and surgical specialists,	Physician orders 1.operative reports
Ongoing treatment and progress	nurse anaesthetists	2.progress note 3.anesthetist report
Nursing support and intervention	Nursing staff	Nurses related records
Discharge	Physician	Final diagnosis, discharge summary
Autopsy	Pathologist	Autopsy report

Outpatient Record

Outpatient records are those which are sent to outpatient clinics in conjunction with the treatment of patients. After the patient is seen in the clinics, the patient file should be returned to the O.P clinic clerk (AMRT). Outpatient records are not to be retained by any one including physicians. If patients require admission, the file is sent to the admissions office. For admitted cases, the inpatient procedure is applicable.

Day care Record

Day cares patients are those patients who are admitted and discharged on the same day without the overnight stay. A special area earmarked for day care cases to deal with minor surgical procedures or observation. Since it is not considered as inpatient, and the treatment rendered can be recorded in the outpatient folder / file.

Inpatient Record

From the time of admission into the ward, until the patient is discharged, the patient file is under the custody of the ward nurse. This file should not be taken out of the ward without her permission. The maximum time permitted for discharged patient files to be retained on the ward is 48 hours.

An AMRT from the statistical unit of medical record department is responsible for the collection of the daily ward census and the discharged patients files (whether complete or incomplete) from the ward each day.

Patient Medical Files Sent to Other Hospitals

As a routine, a patient file from one hospital is not transferred to another hospital. However, a detailed discharge summary may be supplied to the treating physician. In exceptional cases, a photocopy of the entire file is supplied and the original file is retained in the hospital.

Patient Medical Files from Other Hospitals

Any patient file from another hospital which is received for treatment of the patient should be returned to the concerned hospital. The file should not be retained even after the death of the patient.

As a hospital policy no patient record should be given out of the MRD except in the following cases.

- Patient care in the outpatient, inpatient, day-care or emergency.
- Medico legal cases.
- Administrative investigations and financial settlements.
- Clinical meetings.

STATISTICS

Hospital statistics play a vital role in a national health information system. The medical record department, which is the main source of hospital information, not only provides clinical data concerning patients but also furnishes data on other activities in the hospital such as administrative and financial concerns.

Hospital statistics can be defined as a collection of numbers that present facts for use in a health care facility. Statistics may involve a tally of the number of times a treatment is performed, or the number of patients in a particular medical facility. In other words, "statistics" are facts set down as numerical figures. To serve a purpose, such figures must be relevant and reliable to be evaluated adequately and to be

utilized accurately for decision making. Accuracy, should be the number one priority for collecting any statistical data, however, the following seven points also merit consideration.

- Reliability
- Validity
- Completeness
- Timeliness
- Accessibility
- Confidentiality, and
- Security

Accurate and comprehensive hospital statistics are essential for:

- Providing the best quality of patient care.
- Evaluating the competency of the medical, nursing, and ancillary staff;
- Preparing operating budgets and cost control.
- Administering control over functional activities by controlling bed allocation, infection, mortality rates, and length of stay.
- Planning additional facilities, staff, equipment, and education, as well as improvements in patient care.
- Assisting a national health agency to monitor health institutions and to help these facilities meet the countries health needs.
- Augmenting international organisations in the control of infectious diseases, in the prevention of epidemics, and in the prevention of epidemics, and in the coordination among different nations of the globe in achieving optimal health for each and every person.

Collection of Hospital Statistics

All hospitals should collect and compile different types of statistics as recommended by the hospital board, state or federal laws, or the Ministry of health. Some of the essential statistics to be collected are as follows.

Outpatient Including Day Care Statistics

- Statistics of new, follow-up, and established cases: documented according to nationality, sex, clinical service or unit, geographical distribution, and age group
- Number of investigations carried out: e.g. by pathology, microbiology, biochemistry, radiology, ECG, EEG, and other specific departments
- Outpatient disease and operation statistics.

Emergency Statistics

Total number of cases seen in the emergency services and classification according to nationally, sex (male, female and children), number of cases referred to OPD and PHC. Number of cases admitted in the hospital and number of medicolegal cases treated (accidental, suicidal, homicidal, traffic, accidents, burns, and poison cases).

Inpatient Statistics

- Daily census reports of admitted and discharged cases of general and private wards.
- Discharges by service according to nationality, sex, age group, and discharge results (discharged alive, died less than 48 hours after admission or died more than 48 hours after admission)
- Bed utilization (general wards and private wards are considered separately): patient days and bed occupancy rate.
- Inpatient diagnosis and operation classification statistics.
- Number of physician consultations received and rendered.
- Surgical procedures classified according to different clinical services with the number of elective operations, emergency operations, minor operations, intermediate operations, and major operations performed.
- Diagnostic investigations including the number of pathology, microbiology, biochemistry, radiology, ECG, EEG, other tests conducted.

- Deliveries conducted encompassing the number of normal and abnormal deliveries. Births: the number of live births grouped by mature infants, pre-mature infants, and stillbirths.
- Diet supplied entailing the number of normal and special meals.
- Death statistics including the following data: patient number, nationality, sex, age, clinical services, and length of stay, and any other pertinent remarks.

Administrative Statistics

- Number of medical personnel: seniors and juniors according to speciality.
- Number of dentists: seniors and juniors.
- Number of nursing personnel according to cadre and also student nurses if any.
- Number of paramedical workers including laboratory, radiology, dietary, pharmacy, medical social service, medical records, and others.
- Other auxiliary services: civil engineering, electrical engineering, maintenance, laundry, and housekeeping.
- Administrative staff including director, deputy directors, office unit heads clerical and lower grade staff.
- Expenditure relating to: drugs, diet, equipment, furniture, forms and stationery, buildings including water, electricity, personnel, linen (patient uniform, staff uniform), transportation, communication, maintenance, training of personnel and research.
- Income from patients and other sources.
- Other information pertaining to administration.

Medical Records services of guide for Hospital A good M.R.D. Must contain all the below statistics. A good M.R.D. must contain all the below statistics.

- Inpatient discharge analysis.
- Monthly and Annual Reports
- Death rates(Net death rate, Anaesthesia death rate, post operative death rate, pregnancy death rates)

- Autopsy Rates
- Death due to Infection
- Length of stay
- In-patient bed occupancy
- Census of in-patients and out-patients
- Bed Turnover rate.
- Disease wise statistics
- Operation wise statistics
- Doctor wise statistics
- Department wise statistics
- State wise statistics
- City wise statistics
- age wise statistics
- No. of Admissions
- No. of discharges etc.

Statistics of Major Departments

The statistics of major departments such as pathology, microbiology, biochemistry, radiology, ECG, dietary, anaesthesiology, physiotherapy, obstetrics, gynaecology, and the operating theatres, must be collected providing important data and which is submitted to the medical records department each month.

Monthly Statistics

The medical records department should prepare monthly statistics of outpatient, inpatient, emergency, and allied departments and publish a monthly report. Copies of monthly hospital statistical reports should be distributed to the following departments each month:

- To the hospital director.
- To the heads of departments and unit chiefs.
- To the vital health statistics directorate.
- To the central medical record department of the ministry of health.

Modern concept of health care is not only to restore health but also to protect and to promote it. Medical Record serves as a store house for various data on health intelligence.

- **HEALTH STATISTICS:** Medical Records help to evaluate the health requirements of the community and for proper distribution of the limited budget. It provides back ground data to Administrators and planners to plan to for the future.
- **MORBIDITY STATISTICS:** Medical Records help public Health Officers in the prevention and control of communicable diseases it en pharmaceutical concerns to access their market demands.
- **DISEASE WISE STATISTICS:** Medical Records helps to forecast epidemics and to take preventive measures. It is also useful for teaching and research purposes for clinical trials.

Therefore efficient documentation, good Retrieval System with efficient cross reference are very necessary for an ideal M.R.D. Medical Records should be perfect because "PATIENT FORGET, BUT RECORDS REMEMEBRS".

Compilation of General Health Statistics

- Total patients discharged
- Average length of stay
- Total deaths
- Deaths under 48 hrs
- Deaths over 48 hrs
- Percentage gross death rate and net death rate
- Total patients admitted
- Total patient days of care to patient in hospital
- Daily average number of patient
- Average percentage of beds occupancy
- Births in the hospital
- Operations conducted during the month in various disciplines
- Minor as well as major

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- Complication of unit wise distribution of admissions and discharges along with percentage geographical distribution of patient admitted
- Complication of new and old cases attendance in OPD's and special clinics and compilation of data for annual report.

* * *

UNIT IV

MEDICAL FORMS & REGISTERS

Introduction

Medical record forms are essential ingredients for smooth and efficient functioning of the hospital. The service provided by medical, nursing, and other allied staff to either an outpatient or an emergency patient is documented to serve not only as an effective means of communication but also to serve as an authentication of treatment rendered by whom, what, how, why, when, and where. Proper documentation of patient care needs well designed and available forms, registers, and reports at all times. Aside from efficient care to patients, medical records facilitate medical education, medical research, and medicolegal endeavours. In view of their paramount importance in health care administration there is a dire need to design suitable forms, and to develop suitable forms, and to develop a suitable formula (Standard) for estimated cost requirements in order to allocate an appropriate budget.

The design of forms is necessarily one of the principal functions of a medical record officer. Hospital personnel such as physicians, nurses, and other ancillary staff are busy people; the reduction of the paperwork burden is a boon to all concerned. The degrees of skill are forethought employed in the preparation of forms impacts not only their efficiency and economy of use but also the accuracy and completeness of the information recorded.

General Considerations

There is multiplicity of forms utilized in every hospital and it is essential at the outset of any forms design program to ensure that each form fulfils its function precisely without unnecessary overlap with other forms completed for the same patient. Each form already in use should be subjected to severe scrutiny concerning ease of use and satisfaction of those utilizing the form. The forms should be up-to-date, lack ambiguity, and most importantly, be adequate for patient care, and yet should be economical in use in terms of paper, printing, and equipment required. A well-designed form facilitates the obtaining of

more complete information and expedites the efforts of documentation as well as the quick and efficient retrieval of data.

FORMS

What is form? A form is am model or a style, a method of arrangement of details, an official document with blanks requiring completion. A form can be defined as a "piece of paper or card on which a formal arrangement of information is designated usually with spaces for the entry of additional data". Therefore, a form is a means of conveying information or instructions clearly without risk of misinterpretation. A form is an essential tool for documentation which permits uniformity in paper work and which, as either paper or card, must bear clear headings and a logical sequence of entries in order to facilitate both the entry and conveyance of information accurately. There are two types of data usually found in a form:

- Fixed data as in pre-printed caption, titles, rules, or instructions
- Variable data with information subsequently added to the form, either manually or by a machine.

Forms users are categorized mainly into two groups:

- Those who originate the information
- Those who act based on the information.

The needs of both groups must be closely examined to ensure the production of a good form suitable to both groups.

Standardization of Medical Record Forms

Medical record forms include: the medical record folder (patient record outer manila folder), the x-ray file jacket, index cards, clinical documents including medical, nursing, and paramedical diagnostic investigation requests and reports. Other forms include registers, administrative and legal documents such as birth, death, and other notifications, as well as statistical reports have to be standardized. If the content and design of forms is standardized, decisions must be made regarding the forms to utilize and the latitude permissible for their modification since two or more versions of the same form may be

necessary, e.g. a very simple antenatal record for use in health centre and a more complex one for use in a secondary or tertiary hospital. Provisions must be made to revise forms periodically to keep pace with changes in health care programs and technologies.

Availability of Forms

The best designed form does not serve its purpose if it is not available to the individual who must utilize it when he or she needs it. Sufficient thought must be given to the impact of budgetary provisions for forms and to the delegation of authority and responsibility for forms procurement (including the sources for forms procurement, e.g. internal reproduction or commercial printing and the storage and requisitioning of forms).

Development of Medical Record Forms

When developing new forms, it is advisable to have only a small supply prepared for trial use. Initially forms should be simple and few in number, should provide flexibility, and should reduce record. A rubber stamp might be used for special entries in lieu of introducing additional new forms.

Design

In designing medical record forms, the following points should be borne in mind:

- The purpose the form is to serve, and by whom it is to be used.
- The identification of the patient within the form.
- The retrieval of the form.
- The hospital requirements, e.g. consultant requirements.
- The provisions made for form duplication, etc.
- The form number, size, paper quality, multi-part forms print, color coding forms color, terminology, standardized arrangement of data, productivity printing on both sides.

Form Introduction and Revision

Introduction of numerous new forms is not advisable because these forms are not only expensive to produce, but also will confuse users. Therefore, all efforts should be made to reduce to a minimum the requisite basic forms in the medical record. When the basic set of medical record forms has been decided upon and introduced, samples of these forms together with short instructions on their use, should be kept by the health care facility. Decisions on revision or alteration of forms presently in use or on the introduction of new forms should be made by the Medical Record Committee. The individual departments of the health care facility should not be allowed to introduce new forms or to modify form currently in use. There should be a record form committee, responsible for designing and reviewing the medical record forms.

Multipart Forms and Duplication Systems

Multipart forms should be used wherever possible in order to reduce documentation time, to minimize errors, to produce uniformity, to facilitate easy and quick communication between departments of the hospital, and to maintain economy in the printing of forms. The various methods of producing copies or duplicates are as follows:

- Carbon copies produced by hand or typewritten.
  - Loose carbon inserted between forms.
  - Snap-out or interleaved forms (one-time carbon) previously inserted by the printer.
  - Forms with carbonized backing.
- NCR (no carbon required): chemically treated paper.
- Stencils or master copies.
- Addressograph plates (cards)
- Electronic (computerized) transmission of data.

Estimation and Cost

The experience of many medical record practitioners has indicated that hospitals of different sizes and categories, e.g. acute general, chronic, geriatric, psychiatric, and hospitals with teaching and

research activities use basic forms as well as many specially developed forms ranging from a few dozen to over five hundred. With present day escalating costs of health services coupled with general economic recession, there is an urgent need to reduce healthcare expenditures to a minimum without sacrificing the quality of patient care. The capabilities of the medical record officer contribute to the development of basic forms to satisfy the majority of clinical services while keeping the number of forms to the very minimum essentials. The standardization of size, paper, print, color coding, terminology, arrangement data, numbering, production, and quantity forms regularly to meet patient care needs.

Control of Forms

The authority for designing and introducing medical record forms rests with the medical record committee cf the hospital. The medical record officer should submit

The form well in advance. The hospital staff members are not authorized either to introduce any new form or to change the size, format or content of any of the existing 90 or more medical record forms currently in use in hospitals. If any alteration or modification is desired, prior written permission must be obtained from the medical record committee.

Summary and Few Tips

The purpose of medical records is to communicate patient health care and to facilitate medical education, medical research, and legal requirements. It is essential therefore, to design and produce medical record forms at par with international standards. Forms control is one of the important tasks to be exercised by medical record officer. Generally, there will be a lot of wastage or misuse of forms in hospitals, hence, proper measures should be taken to ensure availability of forms at all times. Keep the following few tips in mind when developing new forms in order that proper estimations and cost controls can possibly be effected.

- Select suitable paper, print, size, color, terminology, language, content, form number, and quantity

- Have only a small supply of new forms mimeographed for trial use.
- Revise forms only when necessary
- Avoid colored forms; instead use colored side bands if required
- Use rubber stamps for special entries instead of new form design
- Make the forms easily readable
- Avoid large masses of print; leave plenty of blank space
- Headings, subheadings, wordings should be precise and accurate
- Ensure good appearance by use of good type faces
- Introduction of new forms by individual departments should be avoided; instead the medical Record Committee should authorized them
- Internationally recommended size: A4 for large and B6 for diagnostic investigation request and report forms.
- Print on both sides of the forms which are used frequently.

Just as forms design is not a random process, forms control should not be haphazardly performed either. Forms control encompasses the following objectives

- To insure the efficient design and construction of forms and their integration into all phases of the information processing system.
- To develop and maintain proper specifications for the economical production and usage of needed forms.
- To educate and assist operating personnel in designing their own for when consistent with the aims and controls of the forms control program.
- To stop the origination of useless forms, to combine forms which serve similar needs, to eliminate unneeded forms, and to create additional forms when such addition serves the information processing system better than combined forms.

- To provide an effective brake on the natural inclination of personnel to change existing forms at whim.

In a paper environment, forms control includes: forms inventory, forms identification, ongoing review and revision (forms analysis), and purchasing. In a computerized system, data element inventory takes the places the place of forms inventory and programming logic takes the place of forms identification. Purchasing applies only to special forms of paper (e.g., OCR) input or output.

Forms Inventory

If a (paper) forms control program does not exist, the first step in implementing such a program is to obtain an inventory of all forms. This inventory should then be kept up to date at all times. A forms inventory includes a forms history file and subject/title file.

A forms history file provides a complete picture of each form in the organization from development to current status. It should be arranged according to the numbering system used to identify forms, which should be as simple as possible.

A forms history file can be set up by establishing a folder for each form and filing by form number. Each folder should eventually contain the following.

- A copy of the current edition of the form and any previous editions.
- Drafts showing significant stages of development and pertinent correspondence.
- A copy of the directive authorizing use of the dorm.
- The original request for approval of the form and any requests for revisions indicating the names of all units using the forms and the rate of use.
- Evidence relating to the official final approval for the printing or reproduction and issuance of the form.
- A record of all actions taken on the form, including a cross-reference to the subject/title file.

The forms history file should be periodically reviewed and updated. Folders on discontinued or obsolete form should be removed from the active file on a timely basis, appropriately annotated, and place in a separate discontinued history file for such time as required by the organization's records retention schedule.

A forms subject/title file provides the mechanism by which forms dealing with related subject matter are brought together. One copy of each form is classified by purpose and placed in a subject/title folder.

The Main purposes of the subject/title file are to:

- Avoid the creation of a new form when an existing form could be revised to serve the need.
- Detect those forms which might be eliminated or which might be consolidated with similar forms.

USE OF FORMS

A total of ninety basic forms have been recommended in this book. The personnel using these forms must adhere to the format and contents prescribed and try to complete them as completely as possible, dating and attesting all entries. Generally these forms are self explanatory and therefore further explanation is not needed. However, the following instructions should be observed for effective maintenance of medical records.

Admission and Discharge Sheet

To ensure that accurate and complete information is recorded. The treating physician should document a provisional diagnosis at a time of admission and at the time of discharge should document final diagnosis (principal and associated secondary diseases). If an operation was performed, the face sheet must contain the name of the operation, the aesthesia given, the date and time of discharge from the recovery room, and the condition of the patient on discharge.

History and Physical Examination Forms

A complete history should be written describing the chief complaint, the details of the present illness, an inventory of body

systems, and the patient's past medical history, social history, and family history. The physical examination form should include all pertinent findings resulting from an assessment of all the systems of the body. Without exception, the complete history and physical examination should be recorded within 24 hours of the admission of the patient.

Progress Notes Form

Progress notes should be written as frequently as required or as indicated by the condition of the patient. Progress notes should provide a reference to the condition of the patient on admission. A chronological record of the patients progress should be documented daily or even every few hours during a critical illness. Progress notes should be written as definite and accurate statement, meaningless remarks such as "comfortable" and "doing well" is not acceptable. Progress note should conclude with the summary of the patient's general condition.

Physicians Orders

Orders must be complete, specific, legible, and exact. All orders must be written in ink, signed, and dated. Oral orders and orders over telephone to house staff or nurses should be entered in the record and counter signed by the physician within 24 hours. However, verbal orders and telephone orders are not considered good practise.

Consultation Form

A written requisition filled in on the consultation form and indicating full details of the provisional diagnosis, the objective of the consultation, and all relevant clinical points on which a opinion is desired constitutes the consultation form. The consultant after conducting his own examination then records his findings and recommendation on the same form and signs it.

Consent to Operations and Investigations

A general consent for diagnostic investigation and treatment must be obtained at the time of admission as a routine. Special consent must be obtained for: surgical procedures, discharge against medical advice, temporary leave or absence, photographic imaging, release from

responsibility for abortion, sterilization, organ donation, organ transplantation, or autopsy.

Anaesthesia Record

A complete anaesthesia record indicates the pre operative medications given, the date, time, and effect of these medications, the type and amount of anaesthetic administered, and the technique used. The anaesthetic documents any complications occurring during the course of the operation. He also notes pertinent aspects of fluid balance and the supplementary drugs given to the patient. A graph allows for the visual recording of e.g., the anaesthetic agents used, the depth of anaesthesia pulse, blood pressure, respiration, etc.

Operation Report Form

The operation report form should include a preoperative diagnosis, the name of operation and a full description of the findings, both normal and abnormal of all organs explored and the procedures, ligatures, and the sutures used in the operation, the tissues removed or altered, the postoperative diagnosis, the patient's condition at the conclusion of the procedure. The material (tissue) removed and sent for histopathological examination must be entered in the operation record. The operation report must be written or dictated immediately after the operation if possible, or at least within 24 hours.

Investigation Request and Report Forms

All requests for diagnostic investigations of blood, urine, stool, etc. should contain complete and correct patient identification data. The physician requesting the investigation should indicate the name of the unit or clinic, the provisional diagnosis, and type of test requested in the prescribed manner. This form should contain the date and time requested and the name of the physician requesting the test.

Blood Transfusion Request Form

The blood transfusion request form is retained as part of the patient file. This record should contain the type of blood needed, the amount of blood requested for the patient, the date and time the blood transfusion was given, and any reaction noted.

E.C.G Form

This form includes cuttings from standard leads traced and the cardiologist's impression. The original tracings are mounted on the form in appropriate lead number places.

E.E.G Request and Report Form

The requisitioned should enter full details of neurological signs and symptoms, as indicated, into the request section of this form. He should furnish details of current drug therapy and clinical investigations being done. The neurologist's interpretation of the E.E.G tracings should follow.

Paramedical Services Record

The paramedical specialities, i.e. physiotherapy, occupational therapy, speech therapy, and social work should use this form. The requesting physician should note on the left side of the form, the type of consultation of service needed. The paramedical department technicians should briefly record their observations or therapy rendered on the right side of the form. All notes should be signed and dated.

Nurses Notes Form

Nurse's notes encompass the observations, treatments, and services rendered by them to the patient. The nurses must give a chronological picture of nursing care. Precise nursing notes act as a means of communication among nursing personnel and physicians. These notes should also include the date, time, and manner patients admission- wheelchair, stretcher, ambulation, etc.- interim notes during hospitalisation, and a note written at the time of patients discharge including the date and time of discharge, any advice given to the patient, the manner of patients discharge- wheelchair, stretcher, ambulation, etc. If the patient dies, nursing notes must include the date and time when life apparently ceased, and the name of the physician pronouncing the patient dead. All notes must be signed and dated with the time also indicated.

TPR Chart

The temperature, pulse, and respirations chart allows for a four-hourly or twelve-hourly entry of temperature, pulse, and respirations. There is also space for the graphic recording of blood pressure, as well as written comments on urine, stool, weight, diet, and any other observations required. This chart should be initiated in the ward on the admission of the patient and be continued until the time the patient is discharged.

Fluid Balance Chart

The fluid balance chart is the record of the cumulation of the hourly totals of fluid intake and output. The nature and amount of fluid administered at different intervals should be entered. The total intake and output for every eight hours is recorded. Both sides of this form are generally used.

Medical Record Folder

The medical record folder contains four dividers, e.g. outpatient, correspondence, investigations, and inpatient. All forms related to outpatient care are filed under the outpatient divider. All correspondence and referral forms are kept under the correspondence divider. All the diagnostic investigation reports whether performed for outpatient or inpatient cares are filed in chronological order under the investigations divider. Records of inpatient care are kept under the inpatient divider with the record of the most recent admission filed on top.

Laboratory Mount Sheet

The laboratory mount sheet is maintained as part of the medical record folder. All reports of laboratory investigations must be mounted in chronological order as indicated on the form. Mounting of inpatient reports is the responsibility of the ward nurse while mounting of outpatient reports is the responsibility of the medical record department staff.

X-ray Mount Sheet

The X-ray mount sheet is part of the medical record folder. All X-ray reports must be mounted in chronological order as indicated on the

form. The ward nurse is accountable for mounting the inpatient reports whereas outpatient reports are mounted by the medical record department staff.

Discharge Summary Form

The discharge summary form should be concise and contain only essential information, e.g. a brief history and pertinent physical findings, significant diagnostic investigation findings, the course of treatment including surgical procedures, final primary and secondary diagnosis, patient's status on discharge, and any advice on discharge including the follow-up appointment. The discharge summary, as a routine practise, should be written prior to discharge of patient. However, in exceptional cases, this summary should be completed within a week of the patient's discharge. The treating physician and the unit head should sign the discharge summary.

BASIC MEDICAL RECORD FORMS

FORM NO	NAME OF THE FORM
1	REFFERAL FORM
2	ACCIDENT & EMERGENCY FORM
3	OUTPATIENT FORM
4	HISTORY AND PHYS.EXAM FORM
5	ANTENATAL RECORD
6	O.P.FOLLOW-UP FORM
7	ADMISSION REQUEST FORM
8	ADM.& DISCHARGE SHEET
9	PHYSICIAN PROGRESS NOTES FORM
10	PHYSICIAN'S ORDER
11	CONSULTATION FORM
12	CONSENT TO OPERATION
13	ANESTHESIA RECORD
14	PREOPERATIVE CHECK LIST

15	OPERATION REPORT FORM
16	RECOVERY RECORD
17	EAR, NOSE AND THROAT FORM
18	EYE EXAMINATION FORM
19	PRESCRIPTION OF GASES
20	OBST.EXAM.SHEET
21	LABOR RECORD
22	OBST.DISCHARGE SUMMARY
23	NEWBORN RECORD
24	PED.HIST.AND PHY.EXAM
25	DENTAL TREATMENT FORM
26	HEMATOLOGY FORM
27	SEROLOGY FORM
28	URINALYSIS FORM
29	C.S.F.ANALYSIS FORM
30	BODY FLUID ANALYSIS FORM
31	STOOL ANALYSIS FORM
32	SPUTUM ANALYSIS FORM
33	MULTIPURPOSE USE FORM
34	BLOOD TRANS.REQUEST FORM
35	CHEMISTRY BLOOD GAS FORM
36	MICROBIOLOGY FORM
37	HISTOPATHOLOGY
38	X-RAY REQUEST AND REPORT
39	C.T.SCAN REQUEST AND REPORT
40	ULTRASOUND EXAM.REPORT
41	VENOGRAM REQUEST AND REPORT

42	NUCLEAR MED.REQ.AND REPORT
43	E.C.G. FORM
44	EEG REQUEST AND REPORT FORM
45	EMG REQUEST AND REPORT FORM
46	PHYSIOTHERAPY RECORD
47	OCCUPATION THERAPHY RECORD
48	SPEECH THERAPHY RECORD
49	AUDIOLOGY THERAPY RECORD
50	PSYCHIATRY RECORD
51	RESPIRATORY THERAPY RECORD
52	PARAMEDICAL SERVICE RECORD
53	NURSES NOTES
54	NURSES OBSERVATION CHART
55	T.P.R.CHART
56	MEDICATION RECORD
57	FLUID BALANCE CHART
58	INTAKE, OUTPUT AND VITAL SIGN SHEET
59	DIABETIC RECORD
60	RESUSCITATION RECORD
61	I.C.U.RECORD
62	NEONATAL I.C.U.FORM
63	NOTIFICATION OF STILLBIRTH
64	BIRTH NOTIFICATION
65	DEATH NOTIFICATION
66	ACCIDENT AND EMERGENCY REPORT
67	MEDICAL REPORT
68	POSTMORTEM EXAM AUTOPSY REP.

69	MORGUE BODY REC. AND REPORT
70	DIET LIST
71	OUTPATIENT PRESCRIPTION
72	INFECTION CONTROL FORM
73	INCIDENT REPORT FORM
74	PATIENT ID CARD APPOINTMENT
75	PATIENT MASTER INDEX
76	MEDICAL RECORD FOLDER
77	X-RAY JACKET
78	LABORATORY MOUNT SHEET
79	X-RAY MOUNT SHEET
80	APPOINMENT LIST FORM
81	DISEASE INDEX
82	OPERATION INDEX
83	PHYSICIAN INDEX
84	PRELIMINARY DISCH.SUMMARY
85	DISCHARGE SUMMARY FORM
86	GROWTH CHART BOYS
87	GROWTH CHART GIRLS
88	OUTGUIDE CARD (TRACER CARD)
89	COLOR CODING LABLES
90	PATIENT CHARGES FORM

REGISTERS AND RECORDS

Maintenance of Records in the Wards

Records and reports are an important means of controlling the nursing service. The ward sister is controlling the nursing service and she is usually responsible for the following types of record maintenance:

- Records relating to the care and treatment of patients.
  - Admission record;
  - Discharge summary;
  - History and physical examination;
  - Labour record;
  - Consultation record;
  - Laboratory and X-ray master sheet;
  - Anaesthesia record
  - Operation record'
  - Progress record;
  - Doctors order;
  - Nurses record;
  - Intake and output record;
  - T.P.R chart;
  - Admission and discharge order, etc.
- Maintenance of stock books
  - Drugs;
  - Tablets;
  - Injections;
  - Linen;
  - Diet;
  - Stationery;
  - Instruments;
  - Furniture;
  - Crockery and glassware, etc.

- Hospital administrative records
  - Census report (Admission and discharge register);
  - Paying wards records;
  - Permission for surgical operation;
  - Notification of seriously ill patients;
  - Emergency operations;
  - Deaths and discharges;
  - Medico legal cases.
- Ward maintenance register.
  - Ward maintenance
  - Sanitary;
  - Pantry;
  - Equipment, etc.
- Attendance registers of working staff in the ward.
- Nurse treatment registers (day and night report of the condition of patient).

Records Relating to the Care and Treatment of Patient

From the time, a patient is admitted into the ward and till the case papers are handed over to census clerk after discharge of the patient the sister-in-charge of the ward will hold full responsibility for the safe custody of the case papers. She is also responsible to ensure that the privileged nature of the medical records is guarded. She must make certain that no one has access to the medical records during hospitalization of patient, except persons concerned with the patient care. She must likewise see to it that all medical records of patients are kept in a designated place in the ward, that they are not removed except when a patient is taken to another department for treatment, examination, or study, that not sheets are removed for any reasons and that all laboratory, X-ray and other reports coming to the wards are at once attached to proper medical record. The sister should ensure for the completion of records day to day and especially the bedside nurse's record should be recorded as and when the treatment is rendered. Regarding beside nurses record is mot hospitals the value is not felt and

moreover even if they maintain, it is not up to the standard and it neither reveals any information about patient care nor does it become part and parcel of the patient's record. As a matter of fact it should give vivid picture of observation, treatment and thus serving as a means of communication between the doctor and the nurse as the nurse change shifts and do not always see the doctor.

Hospital Administrative Records

Hospital administrative records include census report, paying wards to the account section for settlement of bills an intimation regarding patient's condition to the hospital authorities for onward transmission to relative or police officials in case of medico legal are have become part of nursing duty as they deal directly with the patient all the times.

Nurses Records

One of the primary responsibilities of the hospital in the proper care of the stick and injured is to provide accurate and adequate medical records and on of the important contributions to them is the nurse's notes. The patient's nursing record is a document which may not only aid in diagnosis off a specific case, but may aid in the treatment of other cases and it is also a legal value.

Good nursing service implies expert observation accurate and complete clinical recording is an extension of the efficient nurse. Clinical recording requires accuracy, promptness in reporting developments and careful itemisation of services performed in carrying out the doctor's orders. The orders of the doctors should be in writing. If an order on this net visit for the welfare and comfort of the patient. The same nurses are not on duty on constantly may be off duty or attending another patient art the time of the doctor's visit, or she may forget about the observation entirely. As such every important observation should be recorded. There is a much value in the elimination of unnecessary detail as in the inclusion of important and pertinent points.

Every observation should be recorded immediately but a treatment should never be charted before it is done. The nurse who 'closes' a chart at midnight, who guesses at a temperature an records it

or deliberately makes a false statement on a record, violates that trust placed in her. All nurse's notes should be singed by the nurse who rendered the service.

Medical records are now preserved for more than 10 years and in some cases permanently for future reference and study and for medico legal protection as such they should be comprehensive, logical, accurate an legible with nothing recorded but factors in medico legal controversies nurse's notes are of immense value as evidence of medical treatment and nursing care.

The nurse's record serves four major purposes

- As a record of the patient's condition during the physician's absence
- As a time saver for doctors and eliminator of errors
- As a proof for the work done
- To complete the medical record

Nurse's Observation Chart

Nursing staff in intensive units or recovery rooms should use this form to do progress estimates of the various physiological indications shown in the columns concerning seriously and dangerously ill patients under their care. This record facilitates the doctor to not the up-to-date date.

Graphic (TPR) Chart

This record is initiated in the ward on admission of the patient. It serves to give the doctor a quick picture of the temperature, pulse and respiration of this patient during his absence. It also provides the space for recording blood pressure, bowel motions, urine, sputum, weight etc. this form should serve the purposes of an intensive care unit as well as general nursing area.

Intake and Output Chart

Recording of intake and output should be done as indicated. At the end of 24 hrs two redlines should be drawn and in-between these lines, the total 24 hrs intake and output should be recorded provision is

also made, at the foot of the form for the estimates of the current electrolyte balance on the back of orders for intravenous and oral administration fluids.

Chart for Special Cases

There are many special forms. For instance, the diabetic chart, in which space is provided at the head of the form for entry of relevant notes on current diet. Graphic presentation can be made blow of the sugar content of a patient's urine and statements can be given on acetones present, insulin dosage, blood sugar content etc.

In brief, the nurse's record is actually a singed statement of the treatment of the patient. The bedside notes recount the reason for a given treatment and how the nurse carried out the doctor's orders. Emergency cases, particularly of medico legal nature, many of which eventually involve claims for damages, make imperative an accurate word picture of treatment and convalescence.

Other observations which contribute to the usefulness of the record are

- Identification of the patient and the treating doctor
- How admitted by wheelchair, ambulance or ambulatory
- Complete recording of condition of patient on admission and on discharge, noting any mark, bruise and respiration
- Routine and special procedures
- Medications dosage and manner of administration
- Objective and subjective symptoms
- Changes in appearance and mental condition
- Complaints
- Signature of nurse who renders the service

The nurse's record is the part of patient medical record which in a large sense is a complication of scientific data derived from many sources, coordinated into a document and available for various uses, personal and impersonal, to serve the patient, the doctor, nurse, other professional personnel, the institution in which the patient has been treated, the science of medicine and society as a whole.

UNIT V

COMPUTERISATION AND QUALITY CONTROL IN MEDCAL RECORDS

EDNA HUFFMAN says that "That Medical Records is an orderly written report of patients complaints, the diagnostic findings, treatment and end results that in total form a clinical picture when completed, contains sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to record results, "THE PATIENTS, FORGET, REFORDS REMEMBER". The record is value to the patient, the attending physician, to the hospital and for research and teaching.

Modern events in Medical records, of which computerisation a key procedure in Data-Processing is an orderly day-to-day or month-by-month method of collecting information whether done manually or mechanically. The term 'Data Processing' is practically synonymous with the phrase handling of information. The handling of information about the patients in the hospital is a capsule description of the functions, and we should therefore be aware of the advance in automatic handling of medical, social and administrative data record about hospital patients. One goal of experiments is to develop effective and feasible ways to put all the information now recorded in all kind of medical records into computers. It could be retrieved either in the form of logical conclusions from collected facts, printed copies of all or any desired part of what was put in, of facsimiles of the original records.

Computer is an essentially an extension of human mind and therefore computerisation only aims at enhancing or supplementing human capabilities both physical and intellectual in order to meet the increasing complexity of human records.

Greater strides in medical service during the past decades have provided attending physicians and patients with a variety of therapeutic and diagnostic tools which are often interfaced with modern computers. For example, Computerised Axial Tomography (CAT) intensive care monitoring and automated laboratory equipment etc., are common use in

most of the modern hospitals these days. By interfacing a computer graphic to CT Scan machine screen images of a patient's skill can be created in a three dimensional form which helps surgeons not only in diagnosis of the illness but also to predict the result of surgery that might be attempted. The combination of a small computer and a gamma camera is to permit dynamic stud of organs.

Thus, the computers play an important role in present day hospital administration and medical diagnosis, Bio-Analysis and Therapeutic areas in addition to controlling, processing and evaluation of medical data.

The following are the advantage of using computers in hospital.

- It permits immediate access to update information about patients and their full details.
- It permits rapid addition, allocation, and changes to store data, thus keeping them instantly updated with up to date change.
- A computerised medical information system can establish constant standards and continuously monitor all transaction (i.e. admission, billing etc.)
- Its capability for receiving signals from instruments converting them into digital form and vice versa. Processing the information and giving outputs in the forms of reports and display images on the screen gradually helps diagnosis analysis and interpretation laboratory data.

Increasingly computers are being used to handie medical records. Computer can help in three ways.

- They can help to provide a greater quantity and quality of health care per unit of expenditure.
- They can help to curtail raising expenditure.
- They can enable new things to be done.

Firstly, the computers can help Medical Record Department Staff to give patients a better quality of services

Records are more accurate and more accessible, so that patients risks are reduced, and repetitions of tests, and questioning of their validity are avoided.

The computerisation of requesting, reporting and other procedure for lab investigation can be justified in terms of the direct cost savings that result from reducing the time spent by technicians and others, by the major potential gains from the faster, more accurate and more reliable response. They are

- Fewer repeat investigations because date are no longer mislaid or declared unreliable.
- Reduction in patients length of stay, number of O.P. appointments,
- Computerisation of Pharmacy stock-keeping data can be justified by the clerical workload reduction.
- The major gains comes from the opportunity computerisation in stock levels.
- To optimize order sizes for discount purpose to minimize stock levels.
- The capability to relate the bed occupancy, treatment records, lab investigations and other informative data.
- To produce direct patients cost would be a major break through in efforts to identify, transfer and monitor cost effective practices into the general use, thereby helping to them to inexorably rising cost of health care.

A computerised hospital information system generally covers the following application areas.

Administrative Application

- Financial accounting system.
- Pay Roll and Employees information.
- Patients billing and accounting receivable.
- Inventory control in Material Management section, O.T. Stores etc.,

Patient Related Application

We are here more concerned with the patients and medical records and hence it is proposed to discuss on their aspect only leaving the administrative application alone. So far as patient's related application is concerned the following are indicated

In this system, a centralised database of patient's information in respect of admissions, transfers, discharges, deaths, births etc., should be preserved. The data will be entered on line to enable instant updating of patient status to generate several on line and off line statistical reports.

- Reservation for patients on the basis of availability of beds, kind of room demanded. For e.g. general Ward, semi Private Room, Deluxe Room, Super Deluxe Room etc.
- Display of information with respect of any patient about his location, doctor concerned etc.,
- Display of bed availability room wise floor wise etc.

Apart from these reports several statistical reports may also be generated off line periodically wise:

- Daily list of admission.
- Daily list of discharge.
- Daily attendance of O.P
- Doctor Wise statements.
- Departmental wise statements.
- Daily Births and Deaths Reports.
- Age wise Statistics of patients.
- Religion wise Statistics of patients.
- Other daily, weekly, monthly and yearly statistics reports etc.
- Census reports.

Scheduling Of Operation Procedures

This module should provide facility to schedule or cancel operation procedures for patients. It takes into account various constraints like number of operation theatres and consultants and their

current status of availability, duration of each operation required priority of any operation etc., and by using a suitable logarithm can generate the schedule.

The schedule may display theatre wise list of operation to be performed with patient's Hospital number, name, age, sex, operation name surgeons name, anesthetists name, starting name etc., the same may be displayed in the sequence of the patient name with all other details as in the first list. Similar Radiology investigations like, CT scan, Ultrasound Sonography Gamma Camera, MRI etc.

Diet Planning and Catering

The food specification for each patient is made by the doctor at the time of admissions and subsequent diagnosis. Hence it is possible to consolidate diet requirements of all the patients and prepare a menu for the F & B Department. The list would also give Ward wise, Patient Wise ratio requirement for break fast, lunch and dinner.

Medical Records maintenance system should be developed to create a data base for recording patient data.

- Patients first information system (Identification data)
- Admission details.
- Discharge details.
- Length of stay.
- Diagnostic information.
- Procedure information.
- Referral doctor.
- Laboratory investigation details.
- Medication details.
- Treatment and the result details.

The above data may be entered into the computer system either at their points of origin or after logging manually at a later data. The above information may be processed to generate monthly/periodical reports on.

- Disease wise statistics
- Operation wise statistics

- Physician/Surgeon wise statistics
- Departmental statistics
- Geographical distribution statistics and other statistics like averages, length of stay, Death rate, Bed occupancy etc.

More important is medical audit.

Medical Audit programme designed to measure the care received by professional standards. The methodology used in the comparison of actual care received by groups of patients with a set of criteria for high quality care fore each group.

The resulting medical records will provide the medical history of the patient on the terminal when ever required. It may be worth while to keep patient wise details of all the patients admitted in the hospital on line as that would require large disc space.

However patient wise history details may be maintained on-line for selected patients like nephrology patients, cardiology patients, cardio-thoracic patients and others speciality patients which will help retrieving their history details whenever required either on the display terminals or as a printout on the printer.

The Criteria

The Criteria are designed to identify patterns of care from which continuing medical education objectives could be inferred. The criteria are empiric rather than normative since they describe according to the peer panels which set them "Ideal Care". They will of course continually be modified as: they are subject to on-going validation through comparison with "Real Life" Practice, and by the changes what occur in our conceptualisation of the "Ideal".

The purpose of patient care evaluation is to help ensure that care of acceptable quality is being provided. The most efficient way of performing this evaluation is to have physicians/surgeons review medical records. Various approaches can be used to select the records for this review. For example, the records of patients who died, who had prolonged stay in the hospital, who are hospitalised only for a day etc. Another more effective alternative is to:

- Select one or more diagnosis (which occur frequently for study)
- Establish the criteria of good care for that condition is that particular facility or type of facility.
- Review the medical records to determine the degree with which these criteria are being met.
- Recommended corrective measure if indicated.
- Communicate the findings and recommendations to medical staff and other paramedical staff of the facility.
- Repeat the evaluation after some months to determine if improvements have taken place.

Where standards of care for each type of health facility have been developed as part of the patient referral process independent of it. These can serve as a basis for their evaluation. The medical records are to be provided efficiently and effectively to organizational structure, functions, procedures, staff, space, equipment supplies and communications.

COMPUTERISATION OF MEDICAL RECORDS

With the advent of computers in the health care industry, many aspects of health care facilities enjoy a great advantage. Computer usage in health care facilities can be divided into three types:

- Financial
- Administrative
- Clinical

The medical records department is closely associated to all these areas. Computerisation of medical records will improve and help applications in all these areas. Some financial and administrative applications include

- Patient registration
- Master patient index
- DRG (Diagnostic Related Groups) grouping
- Coding and Indexing

Some of the clinical applications are

- Quality assurance
- Utilisation management
- Registries

Medical records departments will gain great advantage by using software packages that enable the following tasks

- Records tracking and location
- Record completion
- Correspondence
- Management of department
- Statistics – compilation and analysis

Medical records department is one of the most suitable departments in a hospital for computerisation of its entire function. Since the department's entire operation deals with information and documentation handling, comprehensive computerised hospital management system would have a significant impact on its daily operations. It would directly benefit medical records by:

- Location monitoring of patient charts;
- Automatic assignment of ICD numbers;
- Improved procedures for generating medical records;
- Simplification of chart-abstracting functions.

As part of computerised hospital management system, documents usually typed in medical records department would be keyed into the system, edited at a computer terminal and entered in the patient chart. If the transcribed document is for a patient currently in hospital, the chart copy could be printed online at the patient-care unit itself.

The rules governing confidentiality of information in a computerised system are the same as those in a traditional record system. Unauthorised release of patient information by means of a printout at a remote computer terminal will have to be guarded against. Hospitals with computerized records system should have records confidentiality policy, and will have to include security devices in their computer programme to prevent unauthorised access to stored data.

COMPUTER

Computerizing the M.R.D. is very useful because computers are very fast and give accurate details. All details of every patient can be feet into the computer. So that they can be recollected whenever wanted.

Uses of Computers In M.R.D.

- ➢ They can help to provide a greater quantity and quality of health care per unit of expenditure.
  - o Records are more accurate and more accessible, so that patients' risks are reduced and repetition of tests and questioning of their validity are avoided.
  - o Fewer repeat investigations because data are no longer mislaid or declared unreliable.
  - o Reduction in patients length of stay, number of O.P. appointments.
- ➢ They can help to curtail raising expenditure.
- ➢ They can enable new things to be done.
- ➢ Statistical reports can be prepared periodically like
  - o Daily list of admission
  - o Daily list of discharge
  - o Daily attendance of O.P.
  - o Doctor wise statistics
  - o Disease wise statistics
  - o Operation wise statistics
  - o Department wise statistics
  - o Geographical distribution statistics
  - o Daily Births and Death Reports
  - o Age-wise statistics of patients
  - o Religion wise statistics of patients
  - o Bed occupancy statistics
  - o Average length of stay of each patient
  - o Census reports

- Other daily, weekly, monthly and yearly statistics reports.
- They are helpful to trace medical records easily.
- Computers are very useful in Medical Audit. It gives details of patent's history and treatment which is useful to measure the care rendered by the professionals.

INACTIVE MEDICAL RECORDS

Inactive MRs. Can be (1) Stored in another area of the facility (2) Commercially stored (3) Destroyed in compliance with record retention statues (4) Micro filmed or (5) Stored on Disk.

Microfilming

Micro film or micro records are the result of a photographic process which reduces an original document to a very small size, resulting in high density information recording and thus considerable space is saving. Because Micro film is self reproducible, reduces paper handling as a micro film copy can be easily made while the original master remains in file. Micro photographic camera lens can reduce the size of the image in terms of reduction ratio 24 to1.

Factors to consider for Micro filming

- **Cost:** Micro filming can be expensive and time consuming because of the equipment needed for in housing micro filming the process.
- **Quality of original documents:** Original documents that have deteriorated will result in micro film of poor quality. Carbon copies and deep shades of Coloured paper do not photograph well.
- **Read ability:** From the users stand point, viewing micro records on readers can be difficult. The user must go to a fixed location to view the micro films records.

Disk Storage

Recently M.R.D. Have been investigating the merits of magnetic disk (or tape) storage & optical disk storage.

Magnetic Disc Storage

- Magnetic Disc Storage allows computer-entered data to be saved on magnetic disk or tape.
- The magnetic medium affords speed of data access and eras ability.
- Magnetic Disc Storage media generally hold more data and allow faster access than magnetic tape.
- The average life of magnetic medium is only a few years.
- However entry of data into a computer to be saved on a magnetic storage medium is time consuming requiring considerable key boarding. Unless data is already input as data originated.

Optical Disc Storage

- Optical Disc storage utilizes a laser to etch data onto a prepared surface of glass or other permanent material.
- It has 8 times the storage capacity of M.D.S. with the same or greater speed of access.
- The non-erasable quality makes it preferable for data retention purpose.
- It is high priced with costs from $150,000 to $ 1 million.

QUALITY CONTROL

Quality control is defined as those evaluation procedures that are performed systematically to ensure conformity with the established policies and standards. This procedure includes the quantitative and qualitative review of medical records and the evaluation of the patient care in medical audit.

Quantitative Analysis

Quantitative analysis is the review of medical records to ensure that they are complete and accurate and meet documentation standards established by the Medical Record Committee and the Ministry of

Health. It is the responsibility of Medical record and statistical personnel to perform this analysis regularly on both inpatient and outpatient records.

Qualitative Analysis

Qualitative analysis is the review of records to ensure that:

- ➢ Sufficient information is contained to justify the diagnosis, the treatment and the end result
- ➢ Opinions are supported by the findings. There are no discrepancies or errors in the records.

This qualitative review should be carried out regularly by the physicians at least once weekly and the medical record committee once monthly.

Medical Audit

Medical audit a "patient care review meeting" in the hospital preferably every month to discuss the patient care carried out by the hospital. The main object of this meeting is to review the overall work carried out in the departments including outpatient, inpatient, and emergency departments, and also to discuss the institutional deaths of the previous month. The attendees at this meeting should include all the clinical staff including seniors and juniors, the director of nursing, the medical record officer, a senior representative from each of the departments of pathology, biochemistry, and radiology. The director of the hospital should be the Chairman of this meeting. He should be very tactful in conducting this meeting because of the potential of sensitive topics. The medical staff secretary should take notes of important discussions during this meeting, and these notes might serve in the initiation of action for any important points brought out during the meeting.

Patient Care Evaluation (Medical Audit)

The purpose of patient care evaluation is to ensure that care of acceptable quality is being provided. The evaluation has to be done by physicians or other healthcare professionals through the review of medical records on a regular basis. Various approaches can be used to

select the record for the review, e.g. the records of patients who died, those who had prolonged hospitalizations, those who left against medical advice, and so forth. Another alternative is to:

- Select 5 percent of discharged patient records on a random basis to be reviewed by the staff selected by the Medical Record Committee.
- Establish the criteria of good care for that condition in that particular facility or type of facility.

Note: The results of the medical should be treated strictly confidential and presented only to the authorized authorities (the hospital director or Ministry of Health) for this perusal.

Role of the Medical Record Department in QAP

The MRD supports the hospital quality assurance activities related directly to the retrieval of medical records, the provision of routine statistical and medical information for completion of reports, the monitoring of adherence to procedures to protect the privacy of patients and quality assurance program.

Evaluation of Medical Record Service

Evaluation of medical record service should provide information on how effectively medical record services are being performed. For example, how accurate is filing in the patient master index; what percentage of records of patients with appointments are in the clinic at the start of the clinic sessions; how accurate is the diagnostic and procedural coding; or how timely are reports being submitted? The Medical record Officer should evaluate the work and the Medical Record Committee should assess and initiate appropriate action.

STANDARDS FOR MEDICAL RECORD SERVICES

Standards are generally, a measure set by a competent authority as the rule for measuring quantity or quality. Conformity with standards is usually a condition of licensing, accreditation, or payment of services.

The hospital must maintain medical records that are documented accurately and in a timely manner and are complete and readily accessible for prompt retrieval of information including statistical data.

Adequate patient case records must be maintained for all inpatients, outpatients, and emergency patients. All significant clinical information pertaining to the patient must be incorporated into the patient's medical records. The content of the medical record must be sufficiently detailed and organised to enable the medical care team responsible for the patient to provide continuity of care, to determine at any time the status of the patient, and to review the diagnostic and therapeutic procedures performed and the patient's responses to treatment. The patient's health record must contain sufficient information to identify the patient, support the diagnosis, and they justify the treatment and end results.

The inpatient medical record must include at least the following complete and accurate identification data.

- A thorough medical history completed within the first twenty-four hours of admission to inpatient services.
- A physician assessment completed within the first twenty-four hours of admission to inpatient services.
- Evidence of appropriate informed consent.
- Reports of all diagnostic and therapeutic procedures.
- Reports of pathology and clinical laboratory examinations as well as radiology and nuclear medicine examinations.
- Consultation reports and progress notes.
- Operative and anaesthesia reports.
- A discharge summary written at the termination of hospitalization concisely recapitulating the reason for hospitalization, significant findings, procedures performed, and treatments rendered the condition of the patient on discharge, and specific instructions given to the patient and family. Medical records must be confidentially assured, currently authenticated, legible and complete. The medical record is the property of the hospital yet is maintained for the benefit of the patients, the medical staff, and the hospital. The hospital is responsible for safeguarding both the record and the information contained within it against loss, defacement, tampering, or use by unauthorized individuals. The

records of discharged patients must be entirely completed within thirty days following discharge.

RESPONSIBILITY FOR THE QUALITY OF THE MEDICAL RECORD

Formation of Medical Record Committee

There should be a medical record committee in all hospitals to carry out regular quantitative and qualitative analysis of hospital services. The medical record committee serves as a liaison between the medical record department and the medical staff. The function of the committee is to review medical records for adequacy and completeness and to determine whether the record meet the required standards for promptness, completeness, and clinical pertinence. To this end, the committee should recommend policies (within the framework of hospital and Ministry of Heath policies) regarding content and completion of medical records. Another important function of this committee is the design and development of suitable medical record forms. The committee must comprise the following members: 1. Hospital Director (medical) or his representative, 2. One representative from each department, e.g. medical, surgical, obstetrics and gynaecology, paediatrics, laboratory, and radiology, and the director of nursing and the medical record officer as coordinators

Functions of the Medical Record Committee

This con.mittee, which is responsible for reviewing various aspects of medical records, is assigned the following functions.

- Reviewing the medical records for
  - Timely completion
  - Clinical relevance
  - Adequacy of the file for use in quality review activities
  - Adequacy of the file for use as a medico-legal activities
  - Recording the tests which were carried out, their results and the therapies given

    - Determining whether sufficient forms are being used in the medical record.
    - Determining the format of a compete medial record
    - Determining the use of electronic data processing and storage methods
    - Determining the classification system to be used in the medical record.
- ➢ Reviewing the security and integrity of the medical records department
- ➢ Checking the retrieval system of the department for easy and quick retrieval

The medical record committee can also select records at random from the discharges and check for substandard and delinquent records. In addition to reviewing the records of discharged patients, the members of the medical record committee, can, at any point of time, make an on-the-spot check regarding completeness of the records of patients who are currently admitted in the hospital. The findings of such checks can be then reviewed at the committee meeting for improving the quality of the records. Decision taken regarding revisions and creations of new policies can be made to rectify any non-conformance found during such check.

The responsibility of the medical record committee does not end with continuously checking only the in-patient files, but the out patient records must also be randomly and periodically checked for completeness and whether the contents of the record are sufficient for continuity of care.

A review of special records, such as those of patients admitted in an emergency or of those patients who have expired within 24 hrs of being admitted to emergency, is also required. Records of patients admitted to emergency due to a calamity or a riot situation should also be reviewed.

Role of the Medical Record Professional

The medical record professional must play an important role in helping the medical staff of the hospital in reviewing the medical records. This is usually done by providing the medical record committee with selected files which carry different kinds of deficiencies and errors. The committee analyses the records and decides on the action to be taken, to avoid such deficiencies and errors in the future. The medical record professional also provides the committee with the summary about the timely completion of the medical record.

The medical record staff must, with tact the diplomacy, ensure that the rules and regulations decided upon by the medical record committee are adhered to by the medical faculty and all other personnel responsible for making entries in the medical records.

Responsibility of the Medical Director

The medical director has the responsibility of spreading awareness amongst the medical staff and stressing the importance of maintaining a high quality in the compilation of medical records. The medical director should ensure that the medical faculty appreciates and adheres to the rules and regulations made by the medical record committee, and thus, enable the hospital create high quality medical records which are worth preserving for future use.

Empowerment of the Medical Record Committee

Only with proper rules and regulations, which are approved and implemented by the medical staff of the hospital, can the medical record committee operate efficient, ensure the completeness of the medical records and be self-regulating, just like any other routine functional group.

The medical record committee must be sufficiently empowered by the management of the hospital.

- To refuse substandard records
- To make decisions regarding the quality of clinical entries
- To implement staff rules regarding delinquent case sheets

- To ensure and encourage the maintenance of high standards of regarding in every way

The management of the hospital must also ensure that all medical faculty, when they join the organisation, must agree to adhere to the rules and regulations of the hospital, may be signing an agreement. For any non-conformance to the existing rules and regulations, the following disciplinary action may be taken by the committee:

- Temporarily suspended admission privileges
- Temporarily suspended consultation and surgery privileges
- Defer promotion
- Reduce privileges

The object of such disciplinary action is not to demean or damage the reputation of the physician, but to lay stress on discipline, on the importance of maintaining high quality medical records and to help in improving it. Many hospitals have rules and regulations whereby the admissions counter personnel are informed by the medical record committee regarding the outstanding records which are incomplete or delinquent, pending against a consultant and the suspension of admission privileges temporarily for that particular consultant.

Medical Records in Infection Control

Infection has claimed hundreds of lives and even today poses a serious threat to human beings. Hospital nosocomial infections are a major health problem in medical institutions throughout the world. Invasion of human body tissues by pathogenic micro organisms acquired by patient 48 hrs or more after their admission constitutes a nosocomial infection. Nosocomial infection embrace all forms of infections acquired in hospitals, but the term is generally applied to infections of wounds, burns, the respiratory system, and the urinary tract, as well as intestinal infections. Infection control is a system which reviews and monitors these infections, recommends appropriate actions and develops policies and procedures to prevent or contain these infections. The Joint Commission on Accreditation of Health Care Organizations states: There shall be an effective infection control program within the hospital. Responsibility for monitoring the infection control program shall be

vested in a multidisciplinary committee that shall recommend corrective action based on records and reports of infections and infection potentials among patients and hospital personnel. There shall be specific written infection control policies and procedures for all services throughout the hospital. The purpose of the infection control committee is to minimize the risk of infection by agreeing to written policies for prevention, surveillance, and control, especially with regard to sterilization and disinfection practices. The committee reports, evaluates, and monitors all records of infection to distinguish between hospital-acquired nosocomial infections and infections acquired outside of the hospital. The committee should include medical, nursing, and laboratory (microbiological) staff along with administrators and medical record practitioners.

Infection control depends upon the information and the database acquired for this purpose. The data should include basic patient demographic data, the data and onset site of the infection, the organisms isolated, (culture studies and antimicrobial susceptibility), the assessment and severity of underlying illnesses, whether the exposure occurred before the therapy was undertaken which might have predisposed it, e.g. surgeries, steroids, or immuno supportive treatment, etc. t he antimicrobial agents used, and some assessment of mortality related to the infection.

A specially designed form is completed and dated by the infection control nurse (ICN) and subsequently transferred to either a manual system or preferably to a computerised system for both storage and analysis. Commercial software packages have made computers (even microcomputers) potentially useful tools for infection surveillance and control. Software which not only merges the data collected by the ICN, but also applies tabulations and rate calculations, provides output which is meaningful in making assessments of the needs for disparate forms of treatment as an effective means for helping with infection control. In order to minimize the infection rate, a wide variety of sources of information must be collected. The admission officers, the laboratories, the pharmacy, and clinicians need to provide this information.

The department of medical record as a storehouse of health information has much to contribute to the infection control process. This contribution beings with the departmental role in the design and development of forms for the collection and collation of needed data. Each patient care records must contain complete information that justifies the patient's final diagnosis. The medical record department should notify the attending physician in cases where infections were not documented but the physician or were not included among the final diagnoses. Special forms must be developed to enable the infection control staff to act promptly and effectively to collect data in cases of suspected infection encompassing identification details, contributing factors, radiological evidence, microbiological evidence, findings and comments of infection control officers and environmental factors responsible for dissemination of infections. Data to be collected in neonatal units include identification details, the sites of infection, the onset in days, any risks factors predisposing the infant to maternal or neonatal infections. Nosocomial infections records are maintain for each ward for a determined period, in which site might well be elated by speciality or by site of infection as well as correlating nosocomial infections by ward and site by ward and pathogen by site and pathogen and the overall ward incidence rates. Additional surveillance data would include surgical infections in clean operations. Laboratory records should be kept for retrospective epidemiological investigations and for quality control activities. Records of results of antimicrobial sensitivity tests and of special biochemical reactions should also be retained.

General Instructions

The following instructions should be meticulously observed to obtain complete and accurate patient medical files for efficient patient care:

- Every sheet of each patient medical file should contain identification data including at least the patient's full name and hospital number.

- The treating staff whether medical, nursing, paramedical, or others must sign and date each and every entry made; each progress note must be attested and dated.
- Generally verbal orders or instructions for rendering patient care are not encouraged, however, in emergency situations this manner of directive may be practised by authorized staff. These verbal orders and instructions should be recorded in the patient file at the earliest opportunity within a few hours by the same staff member who gave the verbal instructions. The responsibility for completing the file rests with the staff member who gave the verbal orders.
- All return entries into the patient file including investigation requests and reports must be clear and legible. Since patient files eventually are micro filed later, it is advisable to document them using a dark colour ink. Pencils must not be used. Each entry must be dated and must include the name and status of the contributor.
- Any entry into the patient file should not be erased, if corrections are required, circle the error and write the correct entry below it and the sign the new entry.
- Patients should not be admitted onto a ward without completing the admission request form presented by the treating physician or by any authorized medical officer.
- Patients should not be discharged without written discharge instructions from the treating physician.
- A provisional or admitting diagnosis must be documented at the time of admission whenever possible.
- Diagnoses must be written in full without the use of abbreviations.
- Standard abbreviations are listed separately and only those abbreviations should be used.
- Prior to the discharge of a patient, the treating physician or his authorized assistant should document the final diagnosis

including the principal diagnosis and associated secondary diagnosis, Along with the condition of the patients on discharge, the end results, and any advice given to the patient.

- The cause of death (if uncertain) must be documented in the record of all death cases. If any autopsy is conducted, a note "autopsy done" should also be recorded.

Responsibilities of a Patient

The patient is responsible for the following:

- To furnish correct and full identification information; full name, age (date of birth), occupation, father's/ husband's name, nationality, and complete address including telephone number.
- To give correct information regarding his or her previous visits to hospitals and to furnish information regarding present complaints, past illnesses, hospitalisations, and medications.
- To retain the appointment (hospital number) card safely, and to produce this card whenever he or she visits the hospital or health clinic.
- To inform the hospital authorities on the loss of a hospital number card so as to retain the correct hospital number.
- To inform the hospital at the day and time of appointment and to avoid going to hospital without prior appointment except in case of an emergency. If the patient is given a follow-up appointment for future visits, he or she should register and obtain a date and time for the next visit before leaving the hospital.
- To report only to the authorized staff in the hospital for his or her appointments.
- To observe the rules and regulations and strictly follow instructions of the hospital and never remove hospital records except the patient appointment card and specific documents given to patient.

- To avoid making wrongful alterations in his or her records, to avoid giving wrong information or producing wrong documents such as bringing records of other patients when seeking personal care.
- To be considerate and respectful of the rights of other patients and of the hospital staff by assisting in the control of noise, and by limiting the number of visitors, whenever necessary.

* * *

UNIT VI

LEGAL ASPECTS OF MEDICAL RECORDS

The medical record is the who, what, why where and when of patient care in the hospital. With the advancement in medical knowledge and complexity of modern medical and surgical treatment existing in hospital today, an accurate and adequate medical record is essential as documentary reference of the care and treatment which the patient received in the hospital.

Mc Gibony has said, "A chronicle of the pageantry of medical and scientific progress is found in the hospital records. There may be found the running story, disconnected, it is true, of the drama, the comedy, the mystery, the miracles of medicine and hospitals of the twentieth century:

Each medical record reveals information, always centred around a patient (who may be a man woman or a child).The patient is the recipient of the medical care, which is offered to him by a team which usually consists of the doctor, the nurse and the paramedical worker. This care is offered by the team to the recipient(patient) in a particular location, this being the hospital. All activities by the team in this location are for the benefit of the patient and this is recorded, thus making the existence of the hospital medical record possible.

The hospital compiles and keeps medical records primarily for the benefit of the patient, and the protection of the hospital and physician. However, the personal data contained therein, considered as a confidential communication, is a property interest of the patient. In addition to being kept for the benefit of the patient, medical records are also kept as a guide to consultants, for the education of undergraduates and postgraduates, for the training of the nurses, medical statistics research and the protection of the physician, hospital staff and hospital against unjust criticism.

When the hospital admits a patient, it enters into an implied contract to render services necessary in the care and treatment of the patient. This necessitates keeping a chronological record of the care and treatment rendered by the personnel.

Confidential Communication

Medico legal problems often concern the hospital administrator but he, in turn, transmits the responsibility to the records department personnel, (if there is a medical records department) otherwise this responsibility is usually vested on the casualty medical officer. The treating of medicolegal cases are day-to-day problems and it is necessary that policies governing the release of confidential information should be clearly defined by the administrator, and the medical record must be safely guarded from unauthorized inspections. The medical record is used either as a personal or an impersonal document.

Personal Document

As a personal document the record is used to identify the patient with the history of his illness, the physical findings and the treatment given to this one individual. The information is confidential and may not be released to anyone without the patient's permission. However, the executors of an estate or their legal representatives, in as much as they are supposed to act in the best interest of the deceased, should be allowed access to the record if this becomes necessary for the performance of their duties. This access to the records may be permitted only after presenting proof of authority. Neither relatives nor friends of the patient, not even the husband or wife, have any right to review a record unless authorization has been received from the patient. The authorization should always be in writing and should be filed with the record, together with a carbon copy of the information released.

It must be recognized that if a record is subpoenaed it must be produced in court. Usually a member of the records department represents the hospital in producing this record in court. It is recommended that a Photostat of the record should be retained in the hospital and the original sent to the court. Past experience has being that at times, the court retained the original record for an indefinite time and in such occasions the Photostat copy fulfils the purpose.

If the patient should be readmitted under the care of a second physician, the second physician should be allowed access to the record of the previous hospitalization. If the patient is subsequently admitted to

another hospital, a summary may be sent upon request from the hospital or the physician. In such an instance, an authorization is not usually considered necessary as the information is being released in the interest of better patient care.

In case the patient personally requests of the information from his own, record, it is not always in the best interest of the patient that he knows, all the details concerning his illness. It is a wise policy, in all such instances, to consult the physician. It is doubtful, however, whether the hospital would be justified in refusing the information to the patient even against the advice - attending physician. It must always be kept in mind that laws differ from country to country and even from state to state, and therefore, one should acquaint himself with the legal requirements of the particular state.

Impersonal Document

As an impersonal document, the record may be used for research or study, when such cautions need not be exercised as when it is used as a personal document because it has no connection with the patient as an individual. Moreover, it is used in this manner only by physicians, House-Surgeons, Under-graduate students, nurses and paramedical staff, all of whom are bound by the code of professional secrecy. In such instances, the record of the individual loses its identity as a personal document and only the record number and so it is unnecessary to obtain the patient permission.

If the research is being done by a staff physician and is not for publication, it is not necessary to obtain the permission of the attending physician to use the record, although this is done as a matter of courtesy. If the record is being studied preparatory to publication, the permission of the attending physician must be secured, as it might be his intention to use the data for his own publication. It is very essential, when a physician, who is not a staff member, wishes to review a case or series of cases, that the consent of the attending physician and permission from the hospital administrator must be secured.

Hospital medical records can be documentary evidence as per the Indian Evidence Act, 1872, as amended up to August 1, 1952, 1961 and

medical records are generally subpoenaed to court in the following types
5209 of cases:

Insurance Cases

Frequent requests come from the Life Insurance Corporation regarding details of the hospitalization of a patient. This is done with the purpose of disposing of claims that may have arisen for settlement as the patient is insured with the corporation. With the help of the hospital medical record, various forms of life insurance are completed. Though the information that is made available from the hospital medical record is a privileged communication and the document in this respect is used as a personal document, yet the release of such information without the prior consent of the patient is permissible because the patient had waived his claim of this privilege at the time of taking out a policy with the corporation.

Workmen's Compensation Cases

The Workmen's compensation Act of 1923 as amended up to 1942, provides for the payment, by certain classes of employee to their workmen, of compensation for injury caused by accident arising out of and in the course of employment. A commissioner appointed under section 20 of the above act awards the compensation as prescribed in the act. A right from the onset is therefore of paramount importance. The medical record in such instances is used as evidence to show the date, the type and severity of the injury, the period of disability and the prognosis.

Personal Injury Skills

In this type of suit, the claim is made by the individual for damages sustained as the result of injuries, which were due to the fault, or neglect of another. The patient may show the extent of the injuries, the treatment rendered and the duration of the care required. The medical record is used to obtain the required data for this purpose.

Malpractice Suits

Malpractice is defined as want of reasonable care and skill or wilful negligence on the part of a doctor., nurse or other staff of hospital

in the treatment of a patient so as to lead to his bodily injury or to the loss of his life. An action for malpractice may be brought against the hospital and its employees in a civil or criminal court. This danger is not so acutely felt in our country at this time, but with the common man beginning to realize his rights and privileges, it will not be long before such things may create problems to the doctor and hospital. The hospital medical record is here used to show whether there was negligence and the treatment rendered was adequate and proper or otherwise.

Will Cases

A patient may have made a will during his hospital stay. After the death of the patient an attempt may be made to set the will aside by seeking to prove that the patient was mental stage of the patient at the time of making the will.

The Income Tax Act

Requests for confidential information concerning a patient are frequently required by the hospital from the Income Tax Officer. This information is available in the medical record. Here, again the medical record is used as a personal document and yet the information has to be made available to the Income Tax Officer by virtue of the power conferred on him under the Section 38 (5) of the Income Tax Act 1922 and no prior permission from the patient is necessary.

Authorization for operation, etc. An operation or even a medical examination carried out without consent expressed or implied of the person concerned will usually amount to actionable assault. A form of consent to an operation should be obtained in all cases although there may be certain occasions when it cannot be done, for example when as emergency operation has to be performed to save life. In some cases the patient will sign the form; in others, such as those involving children and persons of unsound mind, or those who are unable to use their hands or are unconscious, the consent of a spouse, relative or guardian may be obtained. The consent of the husband is needed. If the operation will deprive the wife of her marital functions, and it is wise to obtain the consent of the relatives if there is possibility that the outcome of the operation may leave the patient in a state of distress.

Usually, the completion of such a form is done as a routine either in the Admission Officer or certain surgical wards, and the procedure should be such as to ensure that it is not omitted. Some members of the staff should ensure, before any operation is done, that the form is completed.

Specific consent for amputation of a part, enucleating of an eye, sterilization, therapeutic abortion, etc. should be sought for and properly authorized in writing by the patient so that it may be incorporated in the record to become available as documentary evidence. Though this is routinely done as far inpatients are concerned, it has not yet been introduced in the outpatient service in all hospitals, but some hospitals, are serious about obtaining consent from outpatients also whenever surgical procedure are performed on the patient.

Patient leaves the hospital against medical advice: If a patient is being discharged against medical advice, the signature of patient or relative should be obtained in a prescribed form usually printed on the reverse side of the record. The patient should also be informed of the consequences or risk involved and that the hospital and its employees will not be held responsible for any ill effects which may result. In the event that the patient refuses to sign a release, the clinical record should contain a statement signed by the physician and duly witnessed setting forth the circumstances, reasons and warning against the premature departure. It is the experience of many hospitals that some patients do not appear to have any medicolegal problem during admission, but later the hospital case records of such patients are subpoenaed by the court for various reasons. Therefore, it is advisable that, every patient, whether he appears on admission to be a medicolegal or non-medicolegal case, should always be dealt with keeping the medicolegal problems in view to avoid later complications.

Certificate of Birth and Death

Birth registration certificates provide information for the establishment of parentage, for proof of identity, for proof of birth date for school entrance, insurance for licenses of many kinds, for proof of place as well as date of birth in establishing citizenship and other purposes.

Death registration certificates prove the death of a person for life insurance claims, sickness insurance claims, settlement of estates, circumstances, time and place of birth, etc. Because of the value of the information in these certificates in the lives of people who may need the data, they should be complied with absolute accuracy and should be communicated to the Office of the Birth and Death Registrar. Duplicate copies of birth and death certificates should be filed in the appropriate hospital records.

Criminal Cases

Hospital medical records are used for the following types of criminal cases:

- In murder cases, to show that death did or did not result from natural causes.
- In assault to show the extent of injuries sustained.
- In mayhem cases, to prove the history given by the patient on admission and the character and extent of the injuries sustained.
- In rape cases, to prove the condition of prosecutor on admission and also her history as related on admission.
- In certain cases to prove deficient mental condition and to show that the defendant should be confined to an institution for the mentally ill or feebleminded rather than imprisoned in a penal institution.
- In conspiracy cases, to show that a fraud was perpetrated on a person being sued for damages.

Impact of the Consumer Protection Act in Medical Field

Since 1986, the consumer protection act came into existence the health care providers including doctors, nurses, paramedics and hospital administrators have to be meticulously careful in understanding the full responsibilities that they have to fulfil in the legal and administrative sense. This becomes imperative to ensure whatever the services rendered have to be properly documented in patient records to safeguard the staff

involved in the consumer service. After enacting the consumer protection law, innumerable negligence cases have resulted, which earlier would have been surfaced.

Who is a Consumer ?

Any person who buys any goods against consideration is a consumer. From health point of view the paying patient who receives health services from clinics, health institution, nursing home, etc. is considered to be the consumer.

Why the Consumer Protection Act ?

The legislature has enacted the Consumer Protection Act, 1986 to arm each and every consumer and/or consumer associations with rights to seek speedy, cheap and efficacious remedies. This statue has been enacted to provide for better protection of the interests and for that purpose consumer councils have been established.

What is Service?

It is defined as medical/health service of any type received in any recognized health institutions, clinics, nursing homes from a qualified medical, nursing, paramedical professional by a patient.

What is Deficiency?

Under the Act, deficiency in relation to any service means any fault, imperfection, shortcoming, inadequacy in the quality, nature and manner of performance, which is required to maintain under law.

Medical Malpractice / Negligence

Medical negligence can be distinctly divided into two categories primarily due to incompetence and mere negligence, secondly due to non-maintaining crganized patient record.

Medical malpractice under the law is more than a mere error in treatment or diagnosis. To be judged to be malpractice there must be serious harm caused to the patient as a direct result of the error. Furthermore, the error must be one cause by the negligence of the healthcare provider. Finally, medical malpractice depends on a nebulous and ill defined concept called the "standard of care". Doctors frequently

disagree on what the standard of care is in a particular case that a jury unbiased by previous medical training is frequently the only means of determining whether malpractice occurred. For a jury to convict a doctor of malpractice they must (i) determine that a patient is worse after a treatment; (ii) determine that most doctors would not have given the treatment what made the patient worse.

The medical record is the basic reference document used in medical malpractice litigation. A well-organized, well-written record is the best defence for the competent health care provider. The poorly written, disorganized record is strong evidence of an incompetent healthcare provider. The poorly kept record is not, in itself, proof of negligence on the part of the healthcare provider; but it is proof of substandard care. Because of the importance of lab notes to the conduct of scientific research, an improperly maintained laboratory notebook may actually be proof of research negligence.

Medical malpractice litigation is built around the medical record. The medical record provides the primarily objective record of the patient's condition and the care provided. Records are particularly important for a physician's defence. It is the physician's responsibility to keep the medical records to prove that the injuries were not due to negligence. If the record is incomplete, illegible, or incompetently kept, this is the physician's failure. While courts and juries usually give a physician benefit of the doubt on ambiguous matters, this does not extent to ambiguities created by incompetent record keeping.

When an injured patient seeks legal advice about filing a medical malpractice lawsuit, the attorney's first task is to review the medical records. The attorney is looking for both specific acts of negligence and at the overall quality of the record. The strongest medical malpractice lawsuits are based on well documented specific act of negligence. In most cases, however, the negligence is inferred from documented and undocumented events. If the patient's case depends at least partially on assuming that certain events were not recorded, then the attorney must be able to cast doubt on the credibility of the record.

The least credible records are those that are internally inconsistent. An example would be the situation where the physician's

progress notes report that the patient was doing well and improving steadily, but the nurses' records indicate that the patient had developed a high fever and appeared to have a major infection. More commonly, the credibility of the records is attacked by demonstrating that it is incomplete. If it is clear that medically important information is missing from the record, then it is easy to convince a jury that the missing information supports the patient's claims.

Editing medical records frequently gets their authors in trouble. Physician often keep sloppy records because they are pre-occupied with the patient's immediate needs. Many physicians seem to have forgotten that medical records are intended to benefit the patient. They see medical records as legal formality to avoid medical malpractice litigation. This leads them to "doctor" records to make them look better, unknowingly courting disaster if the record ever is questioned.

Medical professionals are excepted to exercise and provide reasonable degree of skill and knowledge and also exercise reasonable degree of care in treating patients. A medical man rendering professional service for consideration is liable under consumer forum if he falls short of the standard of a reasonably skilful medical person in his field.

The supreme court had laid down that whenever a needy patient specially medicolegal cases, is approaching a practicing medical profession, his responsibility not to completely refuse because the patient problems unrelated to his specialty, but he has to provide a minimum possible care or consultation or treatment and refer to the appropriate medical facilities and document the episode.

Liability of Omission

The doctor / physician before undertaking any high risk treatment or surgery should inform the patient of the risks involved in course of treatment. Any actionable negligence will lead to the payment of the damages by the physician.

The judiciary has the extensive authority Execution of the Consumer Protection Act to investigate in depth to conform in any wilful corrections / alterations have been made in the course of patient care in any institution and penalize much harshly.

Powers of Consumer Agencies

The consumer agencies under the Act enjoys, the wide powers of both civil and criminal courts to adjudicate the disputes in inappropriate legal manner although they act as a quasi judicial bodies.

Place and Time Limit for Filing a Complaint

The complaints are entertained in a district forum within the jurisdiction of the health institution / clinics where the service is rendered. The Consumer Protection (Amendment) Act, 1993 has introduced a new section 24A prescribing the limitation period. All the cases under the consumer protection act should be filed within two years from the date on which the cause of action has arisen.

Duty under Consumer Law

Service rendered free of cost: A medical practitioner rendering professional service free of charge has no obligation under the Consumer Protection Act 1986. A gratuitous patient is not consumer for availing of medical services free of cost. The patient undergoing a medical treatment in a hospital providing the service of doctor free of cost is not a consumer.

Documentation of the Medical Records

- Each and every patient record must contain complete and accurate patient identification data history, physical examination conducted, progress notes, investigation notes carried out, diagnosis, consultations, treatment including medications, therapy, medical, surgical procedures and end results.
- In the course of treatment, necessary investigation reports carried out, including, lab, X-ray, Ultrasound, CT scan, MRI including photographs, etc. have to be clearly documented and the original reports have to be made available.
- The general informed consent for routine treatment in OPD, inpatient, investigations, minor surgical procedures, treatments should be obtained from the patient / authorized patient attendant by the medical record staff at the time of registration in outpatient or inpatient or day care cases.

- A special informed consent has to be obtained by the concern surgeon before performing any surgical procedures.
- The attending / treating physicians are responsible to ensure that the documentation of the pertinent information have to be recorded comprehensively and promptly to justify the diagnosis treatment, and end results, which in turn will protect doctor and the health institutions from any legal litigation's.
- The policies and procedures suggested in this book have to be meticulously followed to safeguard the doctors from any legal actions.

Delegation of Duty

A medical practitioner while treating the patient is personally liable for the diagnosis and treatment, for his negligence the hospital authority is not responsible. But the hospital authority is legally responsible to the patient for due performance of ministerial or administrative duties of its servants.

The Indian Penal Code, 1860

There is a criminal prosecution prescribed under Section 304-A of the Indian Penal Code, 1860 for causing death by negligence. It says-

Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

MEDICAL AUDIT COMMITTEE

Medical Audit is defined as "An objective method of applying an yardstick to the quality of professional performance". The Medical Audit Committee must meet every fortnight. It is attended by all members of the medical staff. The Director and superintendent is the chairman of the session.

Benefit of Medical Audit Committee:

- It gives an opportunity to every one for self evaluation.
- It keeps everyone on the alert to do their best at all times.

- It helps medical officers to share rich experience of service and specialities.
- It enables to know the latest techniques and newer methods in diagnosis and treatment.
- It serves as a training ground for juniors.
- It uncovers inefficient service and points the way to elevate professional standard.
- It enables quick detection of public health hazards in the community.
- It ensures maximum use of the limited hospital services for the needy patients.
- It helps to reduce unnecessary expenditure incurred or indiscriminate use of costly drugs by junior medical officers.
- It improves the quality of medical records for better teaching and research.
- It bridges the communication gap that usually exists between the Hospital superintendent and medical care team.
- It helps in the programme of continuing medical education.

TOOL FOR RENDERING BETTER PATIENT CARE

Medical Records enables to know the previous illness of the patient, treatment given and the investigations already done and prevents duplication of the tedious and expensive investigations already done causing discomfort and unnecessary expenditure.

To The Hospital

It helps to avoid wastage of the limited hospital facilities. It helps to render care with maximum efficiency and with minimum delay and expenditure. The M.R. is of value to the hospital for medico-legal cases. Since the hospital authorities can defend any malpractice suits by justifying the proper care rendered to the subject.

To the Physician

It helps to measure the performance of a physician. It helps the physician to know the history of the patient which enables him to proceed with further treatment of the patient. It defends him form legal suits.

For Medical Research and Training

Accurately and adequately written medical records serves as a media for post-graduate medical education. Medical records provide source materials for preparation of case history and for dissertations, in preparing scientific papers to be read at National & International Conferences and for publication of articles. Good medical records are a pre-requisite for study and research as they serve as a "Mine of Information",

Documentary Evidence In Medico-Legal Cases

According to the Indian Evidence Act, Medical records are confidential legal documents and accepted as documentary evidence for medico-legal cases and insurance claims. Failures to record facts equally bear strong evidence, in favour of prosecution or defence. Accurately and adequately written good medical record serves as a "Big Shield of Defence" in various types of court cases like.

➢ Malpractice suit	➢ Insurance claims
➢ Workmen's compensation	➢ Accident claims
➢ Criminal cases	➢ Patient's Wills
➢ Divorce cases	➢ Rape cases
➢ Heir ship claims	➢ Poisoning cases

MEDICOLEGAL CASES (MLC) REGISTRATION

Medicolegal register: There should be a central medicolegal register kept in the accident and emergency (Casualty) department under the supervision of the Chief Medical Officer. All medicolegal cases admitted from casualty, outpatient, and inpatient services should be registered in the central medicolegal register. A medicolegal stamp

should be affixed on each registered case to ensure that the case has been registered. The completed central medicolegal register should be kept under the custody of the Medical Record Officer.

All medicolegal cases registered in the hospital must be communicated to the police through the hospital administrator to ensure that the medicolegal case records are complete. These cases should be kept under safe custody of a responsible officer in the medical record department.

Safety Procedures In M.L.C.

- Medico-legal cases must be stored separately to prevent loss or misfiling.
- On top of the folder the number of sheets in the M.R. must be written and signed by the clerk for future verification.
- The department must not hand over any paper of the M.L.C. to the patients relatives or friends.

Cases Requiring Registration as Medico-Legal

- All cases of Accidents, Assaults, Burns, Suicide, Poisoning, Rape, Drowning etc., whether brought by police or not must be registered as Medico-Legal in the emergency service department. All patients (M.L.C.) must have a blue folder.
- Request of the patient of accompanying relatives or friend etc., for not registering the case as Medico-Legal is not to be entertained.
- In order to centralize the above arrangement, Registration of Medico-Legal Cases will only be done at the emergency service department and no where else in the hospital. Other departments will ensure this aspect positively.
- Any case of cognizable offence as mentioned in para 1 above, even if brought at a later date by the police, must be registered as Medico-Legal. While preparing the M.L.C. report, the casualty Medical Officer will record his opinion on the basis of the

Medical Examination done on the data of Examination and not as could have been on the data of injury etc.,

- Case with the histories of Criminal interference to procure abortion outside, who report to our Hospital subsequently, should be registered as Medico-Legal.
- In case police requests for the Medico-Legal registration of case already admitted to the Hospital, only comprehensive medical report specifying the nature of injury viz... Simple, Grievous or opinion reserved should be prepared by the Registrar concerned and should be submitted to police through Medical Superintendent.
- If already registered as a Medico-Legal Case in a hospital where he or she reported first remarks to this effect must be recorded in the M.L.C. intimation report.

Intimation of Medico-Legal Cases to Police

- Information of Medico-Legal Cases, attended to or admitted must be sent to the Police Station through Security Department immediately.

Registration and Documentation of Medico-Legal Cases

- All the cases registered as Medico-Legal in our Hospital, must be indicated as such by writing on all the relevant Registers, viz. Accident Register, Ward admission Register if admitted. Requisition Forms for Lab investigations, X-ray Requisition etc., and medical record of the patient.
- In addition to the identification Data, information regarding injuries, conditions of the patient and the treatment given to the cases cited above in I-1 must be properly recorded in accident register and other relevant registers, Forms maintained by the emergency service department.
- 4 copies should be prepared.
  - First copy will go to police through Security department.

- The second one will go to police as Discharge/Death intimation.
- One should be filed with the Medical Record.
- One should be filed in emergency department.

➢ The reports should be signed by the person who attended the patient. Full name and initials of the attending C.M.O. should be written in Block Letters below the signature and stamp of the C.M.O. Apollo hospital should be affixed under the signature.

➢ All Radiological reports, Lab investigation reports should not be handed over to the patients. If the case is M.L.C. all should be sent to Medical records department for filing. If any patient urns up from the M.L.C. charts for treatment, a Xerox copy should be submitted to concerned department.

➢ Only those marks of identification which would lead to the determination of the identify of a person, should be recorded on the Medico-Legal report.

➢ The M.L.C. reports should be completed and signed as soon as possible after the case arrives in Casualty/Emergency department and in any case no later than 24 hours.

➢ In case of rape the cases will be dealt by our Hospital. Register Obstetrics & Gynaecology department, on emergency duty will be sent for the examination of the woman and shall complete the M.L.C. report. It should be countersigned by the consultant.

➢ In the event mass casualties reporting to the emergency department\l the following procedures to be followed

- The term mass casualties will apply to a number more than five.
- C.M.O. or the chief C.M.O. on receiving the information will call the residents/Registrars/Consultants from the departments on emergency duty.
- Medico-Legal reports in respect of cases dealt by the concerned departments will have to be completed by them.

- C.M.O. should not be relieved unless all the M.L.C. reports in respect of patients managed by him during his period of posting in the emergency department.

Custody of Medico-Legal Records

- The M.L.C. records will remain under the custody of the C.M.O. on duty. If there are more than one C.M.O. the senior C.M.O. will be responsible for the safe custody of the records. The M.L.C. records after disposal will be kept under Lock and Key by the Medical records Officer.
- When a subpoena is served to the medical officer, the concerned medical officer should submit a letter to medical superintendent to review the medical record chart. After obtaining the permission from the medical superintendent, medical record officer should give the Medical records Chart. If the medical record char is to be taken away from the hospital, a complete set of medical record charts must be Xeroxed and the Xerox copy should be kept in medical record department. Medical record officer must collect a receipt from the concerned medical officer/person. In case the medical record chart is taken by the Court of Law, a receipt should be obtained by the medical officer/concerned person from the Court and is to be handed over to medical records officer.

Disposal of Patients Who on Examination Are Found Already - Dead On Arrival in the Emergency Department

- The names of such cases should be entered in the BROUGHT DEAD register along with all the possible details about he dead person, obtained from the accompanying relatives, friends or police officials and addresses should also be noted and recorded in the same register.
- In case, where death has occurred due to Natural Cases and there is no suspicion of any foul play, the dead bodies may be handed over to the relatives on their written and signed request and this fact should be recorded by the C.M.O. in the Brought dead register.

- ➢ All other cases where death has occurred due to accident, Assault, Burns, Suicide, Poisoning, Rape or any other cause and where it is suspected that death ahs not occurred due to natural causes, must be treated as medico-legal cases and the patients relatives explained of the procedure and including police intimation and post mortem at G.H. Brought dead certificate can be issued but body must be sent for post mortem with police escort.
- ➢ In the case of Brought Dead, the C.M.O. on duty should fill up the Brought Dead Certificate in Triplicate and hand over one copy to the relatives, one copy to medical records department and the last copy should be filed in emergency department.
- ➢ In case a person is brought dead (D O A) Death certificate, issued should be the separate 'Brought Dead' certificate only and the Corporation from should not be filled. Dead on Arrival certificate should be issued only to patient reference by GP/N.H./ or G.H with valid reference letter and who had died in transit reference letter should be filed with a note stating a brief history along with the copy of the 'Brought Dead' Death certificate. No certificate of any kind should be issued to other cases of dead on arrival.

This Medico-Legal-Cases procedure should be strictly enforced with immediate effect.

As a Departmental Head, the Medical Records Officer/Medical Records Manager is the chief liaison with other departments. He serves as a resource person for other department heads in such areas as record forms and retention release of information, and the many other areas in which he has special knowledge. He also gives orientation programmes to Medical and Para-Medical staff. Today reference is frequently made to patient information systems. Patient information system involves the receiving, storing, processing and communicating of data.

Temporary Permission to Leave the Hospital

As a policy, any patient, who is hospitalized, should not be permitted to leave the hospital. At the discretion of the treating doctor

the patient may be permitted to leave the hospital temporarily for a period of not more than 24 hours. If permitted and the patients fails to return within 24 hours, he or she should be treated as discharged and the necessary entries made in the record. In the case of patients, who return according to schedule, necessary entries of date and time of leaving and returning to the ward should be made in the patient file.

CONSENT

Written consent must be obtained from the patient or nearest relative for medical examinations, investigations, treatments, and procedures performed in the health care facility. In the case of children, persons of unsound mind, unconscious patients, and the consent of the guardian, the spouse or the nearest relative may be obtained. The consent of the husband is required is an operation deprives his wife of her marital functions.

General Consent

Relating to medical examination, investigations and treatment must be obtained by the admission office as routine, in all cases admitted to the hospital.

Special consent

In addition to a general consent, obtained for surgical procedures (operations), amputation, sterilizations, patients leaving against medical advice, donations of organs, post-mortem examinations etc. These must be obtained by the ward nurse in the presence of a witness. The legal responsibility is shouldered by the treating or operating surgeon.

Emergency Operation

Procedure which has to performed to save the life of the patient (for whom consent was not possible), this should be written in the patient medical file " an emergency operation is essential to save the life of patient and cannot be delayed" and should be signed by two physicians including the operating surgeon and the hospital administrator or his representative.

Patient Leaving the Hospital against Medical Advice

If a patient is discharged against medical advice, the signature of the patient or nearest relative should be obtained in a prescribed form. The patient or nearest relative should be informed of the consequences or risk involved and the hospital is not responsible for any adverse effects. In the event the patient or the nearest relative refuses to sign a release, the patient record should contain a statement signed by the physician and duly witnessed setting forth the circumstances, reasons, and warning against such premature departure.

The Oath of Hippocrates

"Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which might not be spoken of at abroad, I will not divulge, as reckoning all should be kept secret.

The Legal Potentialities of the Hospital Medical Record

We need Medical Records in order to provide the best Health care possible. Today, medical care is high of quality and all segments of the Health are System are striving to increase that quality. The medical record is not nobly the documentation of care of a particular patient, but also part of a continually growing Data Base of medical and scientific knowledge. Taken together, medical records contain valuable information concerning he progress which has been made in Modern Health Care. The Medical Records is not only helping the patient but also it helps the physician, Hospital and also in legal purposes. To achieve the goal, proper documentation should be available in the Medical record especially in Medico-Legal Records.

What is Confidentiality of Medical Record?

Information in Medical Records is confidential because it is held that the relationship between patient and physician is special and that their communication should be protected from disclosure. This feeling is supported in the physician's code of ethics and in the law.

RELEASE OF INFORMATION

Confidentiality

Medical records and health information whether in verbal form or written documentation pertaining to any identified patient is confidential. As such the information available either in the form of medical records, disease and operation indexes, computer stored data, microfilm, photographs, videotapes, audiotapes, or any other device used for these purposes should be treated as confidential documents therefore, only authorized staff are allowed to deal with such patient information.

Authorized Staff

Authorized staffs are those who are involved in taking care of the patient, normally including medical, nursing, and paramedical personnel as well as the staff of the medical record department.

Release on information without the patient's permission

- Conditions (e.g. injuries, poisoning, abortions, or cases involving accidents, suicides, and homicides) must be reported to the police or other legal authorities.
- Communicable and other notifier diseases; must be reported to the concerned authorities.
- Events (birth, deaths, and foetal deaths): must be reported to civil registration authorities, either directly or through family members.
- Court order. The hospital is also obliged to provide information in response to a court order. All reports may be made available to the court without the patient's permission.

Code of Ethics

What ever in connection with my professional practice, I see or hear in the life of men, which might not be spoken of abroad, I will not divulge, as reckoning all should be kept secret.

Purpose of Confidential Relationship

To acquire more confidence between patient and doctor, information pertaining patients treatment should be preserved carefully. Patient's authorization is require for release of such information to third part agencies.

- For court needs patients' authorization is not necessary
- For study research and analysis purpose by medical staff patients' authorisation.
- Reports required by court doesn't required patients' letter of authorisation.
- Date of operation, discharge, admissions dates can be given without authorisation.
- With authorisation every detail can be given.

Dr. McGibony had said, "A chronicle of the pageantry of medical and scientific progress is found in the hospital records. There may be found the running story disconnected, it is true, of the drama, the comedy, the mystery, and the miracles of medicine and hospitals of the twentieth century ".

Each medical record tells use a story, and this is always centered on a patient, (Who may be man, woman or a child) the patient is the recipient of the medical care. The medical care is offered to him by the medical care team and this team consists ordinarily of the doctor, the nurse, the dentist, and the para medical workers. This care is offered by the team to the recipient (the patient) in a particular location and location being the benefit of the patient and this recorded and thus making possible the coming into existence of the hospital medical record.

Model Policy for Redisclosure of Primary and Secondary Health Records

When photocopies or other reproductions of health records are provided to authorize external users, these copies will be accompanied by a statement.

- Prohibiting use of the information for other than the stated purpose.
- Prohibiting disclosure by recipient to any other party, and
- Requiring destruction of copies after the stated need has been fulfilled.

As per the hospital policies, a written permission should be obtained before releasing patient information to the third parties which includes any private / government organization or employer.

The informed consent to release information from the medical record should be in writing. Informed consent means that the patient is aware, in a general way, what information will be released and the use that will be made of the information.

The written authorization (informed consent) should include:

- Name of hospital that is to release the information.
- Name of the organization / employer that is to receive the information.
- Patient's full name, age, sex, nationality, hospital number.
- Purpose for which the report is sought.
- Type of information to be released whether complete or partial, in case of partial specific period mentioning the dates, or episode of treatment.
- Validity of the consent (preferably 30 days).
- Date of consent. The signature must be later than the date of medical information required.
- In case of report of the patients who is minor / mentally unsound, the authorization of release of information should be signed by the parent or guardian.
- The information released should be used only to the purpose for which it was issued and later destroyed.

To simplify all the above information, that can be incorporated in the following "Authorization for release of information" form.

The original authorization for release of information form signed by the patient and a copy of the information released from medical record, should become part of the patient file.

Generally, as a policy, even police should also have patient consent to obtain the patient confidential information. However, with the magisterial authority, the medical information concerned about the patient whom is under investigation of police can be released without the patient permission.

The hospital has to determine all the government, and other organizations, to which the confidential medical information can be released by the hospital without the patient permission.

If any hospitals want to maintain the confidentiality of patient care effectively, the patient should not handle the records.

LAW OF EVIDENCE

What Is Law

Law is a rule of conduct Rule is a principle or regulations. Law is enacted for the people, by the people of the people.

What is Document?

It's written evidence written in the business

What is Evidence?

It is a data on which a judgment can be based; a Medical Record can be submitted in the court as documentary evidence.

Types of Evidence?

- **Direct Evidence**

It is a testimony of persons or witness who has actual knowledge of facts acquired by the knowledge of the senses by hearing or seeing.

- **Indirect Evidence Or Circumstantial Evidence**

  It is the testimony of witness by which certain conclusions are arrived by inference. Ex: - negligence of nurses may proved by circumstantial evidence (giving a wrong medicine)

- **Real Or Demonstrative Evidence**

  It is the object itself which speaks as evidence (operating a good eye, wrong correction of fracture etc,)

Terms used in Judiciary

- **Judicial Notice Rule**

  It is the one which allows the court "Awareness of Proof" e.g. without taking an X-ray film treating a fracture leads to a non union of fracture, knowing the full gestation of a pregnant women taking an X-ray film

- **Resgestego**

  Statement declaration of an act. (E.g. gallery falling down due to heavy weight).

- **Hear Say Evidence**

  The dying declarations or evidence or allowed in the court of law. It is not defined in the court of law because the yare given by the patient at the time of death.

Subpenoa

It is a court of order to appear before the court to give oral evidence to identify which is allowed in the court on producing same document.

Medical Records Evidence in the Court Of Law

Anything under business entry rule a record becomes documentary evidence. A Medical Records is prepared while the hospitalization of the patient.

Best Evidence Law

It requires where it becomes necessary to submit the proper original document. Authorized copies (duplicates) can be produced, but when you are asked to produce the original, you not produce it. If you do not have the original you must give explanations and the reason for the failure to submit the original.

Slander

Oral defamation concerning another person there by injury to his reputation.

Libel

A malicious writing, printed or pictorial statements blackening the reputation of another person.

Contempt of Court

Willful disregard of a subpoena.

Lien Laws

Permit hospitals to enter into claims for reimbursement or service rendered to patients.

Battery

Unlawful touching of a person by another.

Tort

An injury or wrong committed with or with out force to the person or property of another.

Mayhem

Offence of willfully maintaining a person.

Defendant

A person against whom an action is brought in lawful suit.

Subpeona Duces Tecum

It requires witness to come along with certain specified records.

Patients Will

If the patient other wise than in a mental hospital or mental deficiency institution expresses the desire to make a will. He is ordinarily allowed to do so in the proper manner and in an appropriate document (form). If any question should arise at a subsequent date as to the mental state of the patient at the time of making the will, this can be settled by examining the information contained in the Hospital Medical Record, which gives the state of the progress of the patient from day-to-day, as entered by the doctor, and it will indicate if the patient was of normal mental state or not.

Malpractice Suits

One of the dangers to be guarded against by the hospital and its employee is the malpractice suit. The patient brings an action for damages in a civil court against the hospital and or its employee if he thinks that he has suffered injury in consequence of negligence or unskilled treatment.

Every person who enters a learned profession undertakes to bring to the exercise of it, a reasonable degree of care and skill so to, when a doctor accepts the patient to use due diligence care, knowledge, skill and caution in administering the treatment. He acts, so to say as an independent contractor exercising professional skill in advising and treating his patient has no control over him. His only remedy when he is dissatisfied is to call in another medical advisor and, if he thinks he has ground for it bring an action for negligence or failure to exercise due skill. How then is the doctor to prove that he exercised due care and to show that the treatment. How then is the doctor to prove that he exercised due care and to show that the treatment offered was correct. It the hospital had maintained the medical record properly, this can be produced for examination and thus prove that the claim made by the patient was not justifiable. The importance of a properly written medical record for this purpose cannot be minimized.

When the hospital admits a patient, it enters into an implied contract to render services necessary in the care and treatment of that patient. This necessitates keeping a chronological record of the case and

treatment rendered by the hospital personnel so that the results may be available. the action for damages be brought against the hospital and if this is found not justifiable then the hospital medical record may have to be produced to demonstrate that there was not negligence involved and the treatment was scientific, adequate, proper and prompt. It follows therefore that in practically every case which goes to court the doctor or the hospital has sound defense which is strength themed by the record written at the time the alleged error occurred and with no thought of future suit.

RESPONSIBILITY FOR THE MEDICAL RECORD

It is the hospital's responsibility to provide a medical record for each patient availing the services of the hospital and to safeguard the medical record and its content from any damage, loss, tampering and unauthorised use.

The responsibility of providing an adequate medical record file is directly or indirectly shared by many members of the medical faculty and administration.

The Hospital Management Body

The hospital management body is responsible for the proper care of the patient can for providing an appropriate infrastructure, by appointing capable and qualified personnel for the efficient management of the hospital. It is the moral and legal responsibility of the hospital management body, as the ultimate authority, to ensure that each patient receives a high quality of medical care, which is documented completely and accurately in the medical record. This they usually ensure by delegating hospital operations to the chief executive officer and medical director.

The Hospital Administration

The prime responsibility of the chief executive officer and the medical director, as part of the administration, is to ensure that the medical and non-medical staffs follow the rules and regulations set by the hospital with regard to patient care. The medical staffs are

specifically responsible for roper documentation regarding the treatment given to the patient. This involves the adequacy, accuracy and timely completion of the medical record. The administration is also responsible for providing proper personnel, space, guidance and equipment for the efficient functioning of the medical record government.

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MODEL QUESTION PAPER

HOSPITAL RECORDS MANAGEMENT

Time: 3 hrs Maximum Marks: 100

PART – A (5 x 8 = 40 marks)

Answer any **Five** questions

1. Trace the history of Medical Records
2. Explain the importance of coding in Medical Records
3. Explain the retrieval procedures of medical records
4. Explain the storage process of medical records
5. Describe the various statistical data that can be collected from medical records
6. What is deficiency check? With illustrations explain the importance
7. What are the activities of medical records
8. Explain the process of assembling in medical records

PART – B (4 x 15 = 60 marks)

Answer any **Four** questions

9. Describe the legal implications of medical records
10. How does medical records facilitate quality service
11. Explain the different filing techniques
12. What are the various forms and registers of medical records
13. Explain the significance of medical records department in a hospital
14. Explain the indexing procedures
15. Describe the different formats of medical records